



Burnsville | Minneapolis | Woodbury | Rochester
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RELEASE OF INFORMATION & CONSENT FORM

It is important that health care providers work together. As such, Valley Medical and Wellness would like your permission to communicate and obtain medical records, when necessary, with your medical providers.

This release form is enforceable from _____ (today) until 1 year from today's date.

Patient Name		DOB	
SSN		Phone	
Address		City, State, Zip	

Organization			
Clinic Name			
Address			
Contact Info.	Phone:	Fax:	

I hereby authorize the release and exchange of information specified below between the above listed organization and **Valley Medical and Wellness**.

This release of information shall be limited to the following specific types of information: ALL MEDICAL RECORDS

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Toxicological Reports/Drug Screens |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Education Information |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Demographic Information |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Progress in Treatment/Notes |
| <input type="checkbox"/> Nursing/Medical Information | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Toxicological Reports/Drug Screens | <input type="checkbox"/> Imaging: _____ |
| <input type="checkbox"/> Educational Information | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychiatric/Psychological Evaluations | |
| <input type="checkbox"/> Drug Use/Addiction History | |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to **Valley Medical and Wellness** in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless authorization authorizes the release of all medical records including: Psychiatric, Alcohol or Drug abuse, Pain management, etc.

Patient Signature: _____ Date: _____