GOLDEN VALLEY
8401 Wayzata Blvd, Suite 150, Golden Valley 55426
P: 763.544.1006 F: 763.544.1008

CHASKA
510 Chestnut Street, Suite 201,
Chaska, MN 55318
P: 952.361.3360 F: 952-513-7968

NEW BRIGHTON
2475 15TH Street NW, Suite D
New Brighton, MN 55112
P: 651.529.1541 F: 651.529.1542

DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Client Authorization for Release of Protected Information

Client Name:_____ Date of Birth:_____

Address:_____

I authorize the disclosure and use of health information as described below:

1. Who may receive and/or disclose (give out) this information:
Name of facility and/or provider: **David Hoy & Associates**

2. Who may disclose and/or receive this information:
(Please print name, address and phone number)_____

Relationship:_____

3. The purpose for which this information may be disclosed:

For Treatment_____ For Care Coordination_____ Another Provider_____
Other:_____

4. What information may be disclosed:
Entire Medical Record _____Behavioral (Mental) Health Records_____Allergy List_____
Most recent physical & history _____Chemical Health Records _____Consultation Reports _____
Other:_____

5. This authorization expires (ends) on the following date, event or condition:

Note: If date, event or condition is not specified, this authorization expires twelve (12) months from date I sign this form.

I understand that:

- I may revoke this authorization at any time by notifying, in writing the facility listed above.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or request a copy of the health information to be disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws.
- Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

*Signature of Client or Client's Representative:*_____*Date*_____

*If signed by client's representative please print representative's name*_____

*Relationship to client*_____

Witness:_____