Golden Valley	Chaska
8401 Wayzata Blvd, Suite 150	1107 Hazeltine Blvd, Suite 121
Golden Valley, MN 55426	Chaska, MN 55318
(P) 763.544.1006 (F) 763.544.1008	(P) 952.361.3360 (F) 763.544.1008

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:

____ ____
Print representative's name *Relationship to client*

Witness: ____