THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE • Pine City, MN 55063 • 320-629-7600 • Fax 651-925-0071

Authorization to Release Protected Health Information

Client Information:	Name:_____ Date of Birth:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
I authorize TSA Inc. to:	☐ **RELEASE information TO:** ☐ **RECEIVE information FROM:** Agency/Name:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____ Fax:_____ Attn (optional): _____
Information to be released (Please specify information to be exchanged):	☐ **Any and all records** Approximate dates of service (optional) _____to _____ ☐ Diagnostic Assessment ☐ Psychological Evaluation ☐ Individualized Treatment Plan ☐ Progress Notes ☐ Coordination of Care Letter ☐ Medical History/Treatment ☐ Psychiatric Records ☐ Chemical Dependency/ Substance Abuse Records ☐ Admission & Discharge Summaries ☐ Court Orders / Legal Documents ☐ Social Services Information ☐ Academic/Educational Records (including copies of IEP and/or 504 Plans) ☐ Teacher/Staff/Counselor Observations or Checklists/Rating Forms ☐ Permission to work with client in school; Scheduling Information ☐ Billing Records ☐ Dates of treatment and/or summary of progress ☐ Other: _____
Release Instructions:	**Information will be released by the following, unless crossed off:** Verbal, Fax, Phone, In-Person and Mail
Purpose of Release:	☐ Treatment/Continuation of Care ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other:_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
I understand that:

- I may revoke this authorization in writing at any time, unless action has already been taken on it.
- Once information is disclosed it may no longer be protected by federal or state privacy rules and therefore may be re-disclosed by the recipient of the information without protections.
- There may be a charge associated with this release of information request.
- Signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practice notices I have received.
- My records may contain information regarding my mental health, substance use or dependency, and may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties identified.

A photocopy/fax of this authorization will be treated in the same way as an original.
Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient's Signature: _____ Date:_____

OR legally authorized representative's signature: _____ Date: _____

Relationship to Patient (if applicable): _____

Directions for completing the Authorization to Release Protected Health Information form

Please read all instructions.
An incomplete form may not be accepted.

Patient Information: Complete the entire section which identifies clearly and legibly the entire demographic information specific to the client (individual who information is being released/requested for).

Party to Release/Exchange Information with: Identify the full name/business, address, phone, fax number and contact information with the name of the individual/agency who we are requesting information from or who we will be releasing information to. Also, please select the appropriate box(s) indicating if you want information to be released to another party or received from another party. If you want to allow Therapeutic Services Agency, INC (TSA) to both share and receive information, please mark both choices.

☐ **RELEASE information TO:** ☐**RECEIVE information FROM:**

Information to Be Released: This section gives us the instructions for what information you want released. If you select "any and all" records, your entire record will be provided for a specific visit date or all dates. If you want to limit the information that is requested or sent to a particular date(s) or year(s), indicate that on the line provided.

Release Instructions: This tells us how you would like your information delivered. Health information includes both written and oral information. If you do not want to give permission for verbal communication to occur, you need to indicate that in this section.

Purpose of Request: Please identify why you need the information to be released/requested.

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you indicate a different date or event. Examples of an event are: "60 days after completion of services" or "once health information is sent". The authorization can be revoked at your written direction to our organization.

Please sign and date this form. If you are a legally authorized representative of the client, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or the patient's legally authorized representative.

Please note that you may only enter one individual, entity, or clinic per each form.

For questions or concerns regarding this form, please contact our records department:

Therapeutic Services Agency
220 Railroad St SE
Pine City, MN 55063
Phone: 320-679-7600
Fax: 651-925-0071