

Release of Information (ROI)

Lifespan Mental Health, PLLC

305 Cedar Street, Suite 102, Monticello, MN 55362

Phone: 763-200-1160 | Fax: 763-645-5458

Patient Information

Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Address: _____

Health Information Release (select one or both)

I authorize Lifespan Mental Health, PLLC to RECEIVE information FROM:

I authorize Lifespan Mental Health, PLLC to RELEASE information TO:

This information is to be disclosed to (select one):

Individual (e.g., parent, guardian, family member)

Organization (e.g., health system, school, insurer)

Provider (e.g., psychiatrist, therapist, other clinician)

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

Information to Be Released

ENTIRE CLINICAL RECORD

(If you select this option, it includes all the categories listed below. If you do not want your full record released, please select only the specific items below.)

Diagnostic evaluations / psychiatric assessments

Medication history and current prescriptions

Progress notes / treatment notes

Treatment plans / summaries

Lab results and medical testing

Medical follow-up visits (primary care, specialists, or other providers involved in my care)

Hospital or emergency department records

Psychological or neuropsychological testing results

- School records / educational reports
- Other (specify): _____

Purpose of Disclosure (check all that apply)

- Continuity of care
- Insurance/payment
- Legal
- School
- Personal use
- Other (specify): _____

Format of Disclosure

- Secure electronic transmission (fax, secure email, or upload to EHR)
- Verbal communication

Expiration of Release

Unless otherwise specified, this release is valid for one (1) year from the date of signing or until the end of treatment, whichever occurs first.

Earlier expiration date (optional): _____

You may revoke this release at any time in writing. Revocation will not affect information already released.

Special Authorizations

Important: Certain types of health information are specially protected under federal and Minnesota law. These records will not be released unless you specifically authorize them by initialing below.

_____ Substance use treatment records

_____ HIV/AIDS testing, diagnosis, or treatment records

_____ Psychotherapy notes (*Lifespan Mental Health, PLLC does not maintain separate psychotherapy notes. Supportive psychotherapy provided during visits is included in the clinical record.*)

Signatures

Patient (if 16 or older): _____ Date: _____

Parent/Guardian (if applicable): _____ Date: _____

Relationship to patient (if applicable): _____