**At Peace Integrative Mental Health Clinic LLC**

19 8TH Street south PMB 424, Fargo, ND, 58103

Office: 701-660-3006 Fax: 701-660-3391

**Authorization/Permission for Release of Information**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I hereby authorize **At Peace Integrative Mental Health Clinic LLC**

 to: **□** Disclose **□** Obtain  **□** Exchange With

 Name of Organization/Individual:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of documentation being requested **□** All Available **□** From \_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_

How information may be communicated via: **□**Written **□**Fax **□**Verbal

**Date Information Needed: \_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be Obtained/Release**

**□** Psychiatric Evaluation **□** Labs/Imaging/EKG Reports **□** H&P **□** Progress Notes

**□** Psychological/Neuropsychological Assessment/Evaluation **□** Testing School Reports

**□** Family Involvement **□** Hospitalization

**□** Other/Specific\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information is necessary for the following but not limited to Diagnosis & Treatment, legal, coordination of care, and insurance purposes. This consent will expire upon fulfillment of its stated purpose or one year from the date of signature. Information release made in good faith prior to receipt of revocation will be considered valid. I understand that I may revoke this consent to release information by **written notice** at any time except when legal action prevents revocation such as probation, parole, court confinement, or when requested by my insurance company, as the law provides my insurer the right to contest a claim under my policy. A photocopy of this authorization is considered as valid as the original.

All records that pertain to mental health, chemical dependency, HIV/AIDs, STDs related testing/information will be released unless otherwise indicated here: (Patient Initial) **\_\_\_**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

 Parent/GuardianSignature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

**\*By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your manual signature.**