RELEASE OF INFORMATION

Patient's Legal Name: _____ DOB: _____
Previous Names if applicable: _____ Phone: _____
Patient Address: _____

Please Release my records ☐ from ☐ to:

Name	Address	Fax and Phone
		Fax: Phone:

1: Release the records marked below:

☐ Medication History ☐ Diagnosis History ☐ Psychological Test Results

☐ Psychiatric Results ☐ Other: _____

All records of treatment for psychiatric/mental health, chemical dependency and AIDS/HIV-related illness testing will be released for the conditions given above unless you tell us not to release/receive those records.

Please specify any restrictions:

2: Please release my records ☐ from ☐ to:

☐ Duluth TMS	☐ St. Cloud TMS
925 E. Superior St., Suite 106 Duluth, MN 55802	3333 W. Division St., Suite 215 St. Cloud, MN 56301
P: (218) 481-0220 F: (218) 481-0325	P: (320) 348-1200 F: (320) 217-5291

3: Delivery Format:

☐ Fax ☐ US Mail ☐ Email (secured): _____

4: Purpose:

☐ Continuing Care ☐ Transfer of Care ☐ Offered Service ☐ Other: _____

5: I understand that:

- If I change my mind, I may write to the address in Section 1 and/or Section 2 to stop the release of my records. This will not apply to records already released.
- Once the records are released to the name in Section 1 and/or Section 2, the place releasing the records cannot prevent them from being shared with a third party.
- My records may include records from other organizations. If these were filed with my record, they may also be released.
- I approve the release of records for future visits, starting from the date I sign this form.
- A photocopy of this completed and signed form is considered valid if not altered.
- I understand that, except for research-related treatment, you will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- This form expires one year after I sign it.

Signature: _____ Date: _____