Naomi Heller, MSW, LICSW

Authorization To Release and Disclose Patient Information

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Health Care Provider (Who has the information you want released?)	CLINIC NAME: Naomi Heller_____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Receiving Party (Where do you want the information sent?	NAME: _____ Attention To: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Information to be released	Routine Record Sets (indicate date(s) of service _____ ___ Clinic (office visit summary, assessment, progress report) ___ Billing Records ___ Any and all records **Only Records types checked below**: ____ Discharge Summary/Note _____ Progress Notes/Clinic Notes ____ Diagnostic Assessment _____ Progress Reports/Court Reports Optional Limits: Disclose only records related to the following: Date(s) of Service _____
Release Instructions: How and when do you want information?	Date information is needed: _____ (Please allow 7-10 days for processing) Release Method/Format Requested: ____ Paper ____ Digital Copy ____ Fax ____ View my Record ____ Verbal
Purpose of Release	____ Continuity of Care _____ Transfer of Care ____ Litigation/Legal

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time.
- Twin Cities Play Therapy Center will not refuse treatment if I choose not to sign this document
- A photocopy/fax of this authorization will be treated as an original
- Twin Cities Play Therapy Center cannot prevent redisclosure of your information by the receiving party of this authorization. By signing this form, you release Twin Cities Play Therapy Center from any and all liability resulting from redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information

_____ _____ _____

Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document)