

MIDWEST CENTER FOR TRAUMA AND EMOTIONAL HEALING

16204 Highway 7 Minnetonka, MN 55345
Phone: 952-934-2555 Fax: 952-934-3010

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client Name: _____ Date: _____

Street: _____ Date of Birth: _____

City/State: _____ Telephone: _____

I authorize Midwest Center for Trauma and Emotional Healing, to obtain, release, or exchange the following information for the purpose of coordinating services for the above named client:

- _____ **Obtain** specified information for my file from the party named below
- _____ **Release** specified information from my file to the party named below
- _____ **Exchange** specified information from my file with the party named below

Name: _____ Telephone: _____

Agency/Institution: _____

Street: _____ City/State: _____

Therapist: _____

Please circle the following information to be disclosed: Oral: _____ Written: _____

- | | |
|---|---|
| Phone Consultation | Psychological Evaluations/Testing Reports |
| Diagnosis | Discharge Summary |
| Progress Notes (including Inpatient/Outpatient summaries) | Social Service Reports |
| Treatment Plan | Medical Reports |
| Social History | Chemical Dependency Evaluation |
| Medical/Medication History | Other (specify) _____ |

Information Restrictions: _____

I understand that this release will take effect on the date signed and will be in effect for (1) year.

I certify that this consent has been given voluntarily and that I may revoke this authorization at any time by notifying my therapist/provider in writing. I understand that my cancellation will not have any effect on information released before the provider received my written notice.

Client Signature Date

Dawn McClelland, Ph.D., L.P.: Date

Witness/Parent/Guardian Date