Prevail Counseling Group, PLLC
6893 139th LN, NW
Ramsey, MN 55303
Phone 763-427-2590 / Fax 763-427-2579

CLINICAL RECORD REQUEST / RELEASE AUTHORIZATION

Section 1

Client Name: _____ Client ID #: _____

Date of Birth: _____

Section 2

[ ] I authorize Prevail Counseling Group, PLLC to send information to:

[ ] I authorize Prevail Counseling Group, PLLC to receive information from:

Name of Agency _____

Address _____
Street, City, State, Zip Code

Phone _____ Fax _____

Contact Person _____

Section 3

Description of Information to be Disclosed

_____ Diagnostic Assessment/Evaluation
_____ Progress Notes
_____ ARMHS Functional Assessment & Treatment Plan
_____ Chemical Dependency Evaluation Notes
_____ All Mental Health Information-Dates of Service _____
_____ Any and all medical records (including billing records and secondary records, mental health, chemical dependency/drug or alcohol abuse treatment records)
_____ Other-specify _____
_____ Treatment Plan or Summary
_____ Billing Records
_____ Psychological/Psychiatric Assessment
_____ Other Facilities/Lab Reports

Section 4

The Purpose of this Disclosure of information:

[ ] Ongoing Care [ ] Consultation [ ] Collateral Evaluation [ ] Family/Support Group Contact [ ] ARMHS

[ ] Outcomes Management Survey [ ] Other – Specify _____

Section 5

I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent ***expires ONE YEAR*** *from the date I sign it unless I request an earlier expiration in writing.*

I release Prevail Counseling Group, PLLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed _____ Date _____
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client _____

Witness _____ Date _____

Prevail Counseling Group, PLLC Office Use Only

[ ] Faxed [ ] Mailed [ ] Picked Up Date: _____ Time of Day: _____ Initials: _____