Cashman Center
Therapies for Mind & Body

Phone: 952-224-8990 Fax 952-224-8991
2970 Judicial Road, Suite 100, Burnsville, MN 55337

Consent for Release of Information

This authorizes Cashman Center to use and disclose the specific health information described below concerning:

Client: _____ Date of Birth: _____
Cashman Center Clinician: _____

This will authorize Cashman Center to release to/obtain from:

Name: _____
Relationship to Client_____
Address: _____City: _____State: _____ Zip: _____
Phone: _____Fax:_____

Information from the medical record maintained from (please list dates such as "all", or 1/16 to 2/17):_____

The information to be disclosed is (please check all info that you are willing to have exchanged):

- ☐ History and Intake Information
- ☐ Consultation Notes/Progress Reports
- ☐ Treatment Plan, Goals, and Results
- ☐ Chemical dependency abuse or diagnosis, history and treatment *(protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)*
- ☐ Social/Psychological/Medial Reports
- ☐ Court or Probation Records
- ☐ Medications used in treatment
- ☐ Other (specify)

The purpose of the information release is (please check all that apply):

- ☐ Diagnosis and Evaluation
- ☐ Treatment Planning
- ☐ To Facilitate Treatment
- ☐ Other (specify)

If we are requesting the Authorization from you for our use and disclosure or to allow another health care professional or entity to disclose information: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) We must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time. This authorization lasts for one year after the date you sign it unless you enter a different date of expiration here:_____

By signing this authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law. You may request that we require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, we will not release the information.

I have reviewed and understand this Authorization. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

Signature of Client_____ Date_____