Arden Shores
COUNSELING

3550 Lexington Ave N. Suite 100
Shoreview MN, 55126
P: 651-583-5565 F:651-583-5566

Authorization to Disclose Confidential Information

Minors, Dependents and Adult under guardianship

Legal Guardian Information

Patient name: _____ Patient date of birth_____

Parent/guardian: _____Relationship_____

Address _____

City/State/Zip_____ Phone _____

Parent/guardian: _____Relationship_____

Address _____

City/State/Zip_____ Phone _____

OPTIONAL Emergency Contact

I, _____ authorize and give my consent to Arden Shores Counseling, LLC to provide information to and from Arden Shores to and from the person/agency named below in the event of an emergency:

Name_____Relationship_____

Address _____

City/State/Zip_____ Phone _____

This confidential information may include (specify extent or nature of information to be disclosed): Presence in the clinic; circumstances of medical or other emergency; medical history; and current conditions. The purpose for this exchange of information is to notify the identified emergency contact(s) of any medical or other emergency involving the patient, and their current whereabouts; and to assist in gathering any medical or other information necessary for emergency treatment.

I understand that mental health records are protected under Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed by this office or re-disclosed by those receiving this information without my written consent, or as otherwise permitted by these regulations.

I understand that this form is optional and if signed will only be used in emergency situations. I also understand that I may revoke this release in writing at any time, except for action already taken. This release will expire in 12 months from date signed, unless another date is specified.

_____

Parent/Guardian Signature Date