Release of Information Request

Patient Information: Name: ___________________________________DOB: _____________

Address: ___________________________________ Phone: ________________

City: ___________________________ State: ______ Zip: ____________

I authorize: Arden Shores Counseling Phone: 651-583-5565

3550 Lexington Ave N. Suite 100 Fax: 651-583-5566

Shoreview MN, 55126 Email: office@ardenshoresmn.com

To: ____Release to _____Receive from _____Both release and receive

Agency/Name:______________________________________ Phone:________________

Address: ____Fax: __________________

City: _______________________________________ State: ______ Zip: ____________

Information to be Released:

- ☐ Most Recent Diagnostic Assessment
- ☐ Current Treatment Plan
- ☐ Past _____ Progress notes
- ☐ All records dated from _____________ to _____________
- ☐ Verbal communication

Please send information by:

_____Fax _____Mail _____Pick up _____Phone/Verbal

Purpose of release:

____Coordination of Care ____Social Security ____Legal Use

____Personal Use ____Other:__________

Patient/guardian signature: ___________________________________Date:_______________

Printed name & relationship to patient____