



Release Primary Care Doctors

Client:	Name:		Previous Last Name (if any)		
	Address			Phone number	
	City		State		Zip
	Date of Birth			Work/Cell number	
Who has the information you would like released?	Name Minnesota Mental Health Clinics (MMHC)		Phone Number 651-454-0114		Fax Number 651-454-3492
	Address 6525 Drew Ave				
	City Edina		State Minnesota		Zip 55435
Coordination of Care	<input type="checkbox"/> I AGREE to allow MMHC to Release my treatment data to my Primary Care Physician. (continue filling out form) <input type="checkbox"/> I AGREE to allow my Primary Care Physician to release my treatment data to MMHC. (continue filling out form) <input type="checkbox"/> I DO NOT AGREE to allow MMHC to Release information to my Primary Care Physician. (sign & date form) <input type="checkbox"/> I DO NOT have a Primary Care Physician that I am currently seeing. (sign & date form)				
Primary Care Physician/ Information	Clinic Name				
	Physician Name		Phone Number		Fax Number
	Address				
	City		State		Zip
Information to be Disclosed:	<input checked="" type="checkbox"/> Any information relating to Mental Health Status or Medication				
Reason for Release:	<input checked="" type="checkbox"/> Continuation of Care <input checked="" type="checkbox"/> On going consultation and exchange of information <input checked="" type="checkbox"/> Telephone Contact				
Revocation:	I understand that I may revoke this consent at any time by providing written notice, and after 24 months this consent automatically expires. I understand that once the information is released by this authorization, we cannot prevent the re-disclosure by the above named party to a third party. I also understand this information will be shared with the treatment team and that refusal to sign this release will not condition treatment being provided. I have been informed of what information will be given, its purpose, and who will receive the information.				
Authorization:	I authorize Minnesota Mental Health Clinics to release the information marked above.				
	Signature of Client		Date	Signature of Parent/Guardian	
	Personal Representative		Date	Date	
A Personal Representative is a person legally acting on behalf of an individual					

Please return all information to:

Minnesota Mental Health Clinics Eagan Clinic-3450 O'Leary Lane, Eagan MN 55123 Phone: 651-454-0114 Fax: 651-454-3492

Visit our Website at www.mnmentalhealth.com

revised 03/25/16