



www.MidWestCenter4U.com

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Woodbury, MN 55125  
Ph: 651-264-0402  
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## Consent for the Release of Confidential Information (Child, Adolescent, Adult)

I hereby authorize the release of Protected Health Information (PHI) from the health record(s) of:

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

Covering the period(s) of treatment: From: \_\_\_\_\_ To: \_\_\_\_\_

PHI to be released:

Complete Record    Discharge Summary    Initial Evaluation    Medical Record

Testing    Other, Specify: \_\_\_\_\_

PHI to be released between Midwest Center and another party/organization via mail, phone or fax:

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Name

\_\_\_\_\_  
FAX

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Mailing Address

### Remit to Midwest Center for Personal & Family Development:

- St. Paul-Main    Burnsville    Edina    Woodbury  
 Anoka    Calhoun    White Bear Lake

Treating Clinician: \_\_\_\_\_

Purpose of Disclosure: \_\_\_\_\_

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in compliance of this consent. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

The facility, its employees, officers, and attending physician are released from legal responsibility or liability for the release of the above PHI to the extent indicated and authorized herein.

I understand that the PHI released could contain reference to Substance Abuse, Psychological and/or Psychiatric Impairment.

**To the Party Receiving this Protected Health Information:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. **FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.**

Special Restrictions: **FAXED ONLY WHEN ABSOLUTELY NECESSARY AND URGENT**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

(Signature of Parent, Guardian, or Authorized Representative if a Minor)