

# Pathways Counseling PLLC

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Phone: 320-732-3344  
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## Release of Information

I authorize: \_\_\_\_\_

*Individual/Facility Name*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip Code*

To: \_\_\_\_\_ Exchange and/or \_\_\_\_\_ Release Information Regarding:

\_\_\_\_\_ *Substance Abuse*

\_\_\_\_\_ *Behavioral/Mental Health*

\_\_\_\_\_ *Physical Health*

To: \_\_\_\_\_ Exchange and/or \_\_\_\_\_ Release the following information:

\_\_\_\_\_ *Diagnostic Assessment*

\_\_\_\_\_ *Conditions of Probation*

\_\_\_\_\_ *Discharge Summary*

\_\_\_\_\_ *Assessment Summary*

\_\_\_\_\_ *Academic/IEP Info*

\_\_\_\_\_ *Rule 25 Assessment*

\_\_\_\_\_ *Other*

\_\_\_\_\_ *Psychological Testing*

\_\_\_\_\_ *Progress Notes*

Records between dates of: \_\_\_\_\_

To be used for: \_\_\_\_\_

Regarding myself or my dependent:

\_\_\_\_\_  
*Patient Name*

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

\_\_\_\_\_  
*SSN(if applicable)*

Records being sent/requested by: \_\_\_\_\_

*Therapist*

### ACKNOWLEDGEMENT OF UNDERSTANDING:

- ~ I understand that this authorization and/or any photocopies of this authorization will expire 1 year from the date signed.
- ~ I understand that I may revoke this authorization at any time either verbally or in writing and my revocation will be in effect the date notified unless action has been previously taken.
- ~ I understand that information gathered from this authorization may not be subject to redisclosure by the recipient and is protected by federal data privacy regulations.
- ~ I understand by authorizing use or disclosure of information obtained by this release, that conditions cannot at any time be placed upon my health care for payment or otherwise.
- ~ I understand that I may request a copy of this form at any time, after is has been signed, at no cost.
- ~ I understand that I may be required to pay a fee for retrieval, photocopying, and supervising inspection of medical records in compliance with MN Statute 144.33 and WI Administrative Code HHS1171.

\_\_\_\_\_  
*Patient, Parent, Guardian, Personal Representative*

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness Signature*

\_\_\_\_\_  
*Date*

I have received a copy of this form (Initials) \_\_\_\_\_