St. David's Developmental & Therapeutic Services
Health Information Management
Phone: 952-939-0396 Fax: 952-548-8685

AUTHORIZATION TO DISCLOSE HEALTH & DEVELOPMENTAL INFORMATION

_____
Client Name Date of Birth

I authorize St. David's Developmental & Therapeutic Services to receive from or disclose my or my child's health & developmental information to the following person or organization:

Name:
Program:
Business Name (if applicable):
Street Address:
City: State: ZIP:
Telephone: Email:

AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:
>Please check all that apply<

☐ Admission/Intake information/reports ☐ Diagnosis & Treatment Plan ☐ Session/Case Notes ☐Discharge Summary
☐ Psychological Assessment Reports ☐ Evaluation Reports ☐ Progress Review/Reports ☐ Medical/Physical History
☐ Medication records ☐ Demographic Information ☐ Information required for case coordination
☐ Verbal Communication (regarding):_____ ☐ Educational Records (including IEP and IFSP)
☐ Billing records/statement (dates)_____
☐ Other (describe): _____

THE PURPOSE OF THIS AUTHORIZATION IS FOR:
>Please check all that apply<

☐ Coordination of Care ☐ Third Party Authorization and Payment ☐ Communication regarding legal issues
☐ Insurance Payment ☐ Determination of eligibility for services ☐ Other Describe): _____

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that if the person or entity receiving this information is not a health plan, health care or other provider covered by federal or state privacy regulations, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying St. David's Developmental & Therapeutic Services in writing and that if I choose to do so, my request to revoke will not affect any actions taken by St. David's Developmental & Therapeutic Services before receiving my revocation. I understand that unless otherwise revoked, this authorization will expire one year from the date it is signed. St. David's Developmental & Therapeutic Services will not refuse or restrict my treatment if I refuse to sign this authorization. A photocopy or fax of this authorization will be treated in the same manner as the original.

_____
Client/Legal Representative Signature **Date**

Legal representative's relationship to client:
☐Mother ☐Father ☐Grandparent ☐Social Worker ☐Foster Parent ☐Other (describe):_____
*St. David's reserves the right to request documentation authorizing you to act as a legal representative.

Tennessen Warning: You have a right to be told the intended use and purpose of information requested, whether or not you can legally refuse to provide the information, what might happen if you provide or refuse to give the information, and who, besides you, will be able to see the information you furnish. Revised 11.8.11