**St. David's Center for Child and Family Development**
**Admissions & Health Information Management**
**Phone: 952-939-0396 Fax: 952-548-8685**

St. David's Center
Child & Family Development

## AUTHORIZATION TO DISCLOSE HEALTH & DEVELOPMENTAL INFORMATION

Client Name (Last, First, Middle Initial) Date of Birth

Street Address City State Zip

Day Phone # Evening Phone #

**I authorize St. David's Center for Child & Family Development to receive from or disclose my/my child's health & developmental information to the following person or organization:**

| | | |
|---|---|---|
| Name: | | |
| Program: | | |
| Business Name (if applicable): | | |
| Street Address: | | |
| City: | State: | ZIP: |
| Telephone: | Fax: | |

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

__ Admission/Intake information/reports __Diagnosis & Treatment Plan __Progress/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): _____
__Release entire record

**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

**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 Center for Child and Family Development in writing and that if I choose to do so, my request to revoke will not affect any actions taken by St. David's Center for Child and Family Development 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 Center for Child and Family Development 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 an original.

Client/Legal Representative Signature Date

Describe legal representative's relationship. *St. David's Center 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