# Release of Information

Client Name: _____ DOB: _____ I authorize Milestone Counseling, Inc. (GKramer, LLC, and Denise Oehrlein, LLC), at 3333 West Division St. Suite 119 St. Cloud, MN 56301 to:

☐ Obtain information from ☐ Disclose information to ☐ Exchange information with

Name: _____

Address: _____ City _____ State ____ Zip _____

Phone:_____ Fax:_____

- ☐ Psychiatric/Psychological assessment
- ☐ Psychological testing
- ☐ Diagnosis
- ☐ Discharge summary
- ☐ Progress notes
- ☐ Summary of treatment contacts
- ☐ Treatment plan
- ☐ School records
- ☐ Medical reports
- ☐ Entire record, except psychotherapy note
- ☐ Chemical dependency treatment
- ☐ Dates of treatment
- ☐ Diagnostic Assessment/ARMHS Diagnostic Assessment Addendum
- ☐ All mental health information (Dates of Service _____)
- ☐ Other (specify)_____

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ At the request of the individual
- ☐ Case review and consultation
- ☐ Other (specify) _____

- ☐ This authorization shall remain in effect until the episode of care ends.
- ☐ This authorization shall remain in effect for one year from the date signed below
- ☐ This authorization ends in less than one year Date of expiration is _____

Dates of service requested:

☐ Complete ☐ Present episode of care ☐ Past seven years of medical records

I understand that this information may be protected by Title 42 (Code of Federal Rules or Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this information is voluntary, and I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

A photocopy is as valid as the original copy bearing my signature.

Client's signature _____ Date: _____/_____/_____

Parent/guardian/personal representative (if applicable)

Signature:_____ Date: _____/_____/_____

Relationship to Minor:_____