# Neighborhood Involvement Program - Authorization for Release of Information
## Couple and Family Counseling

Address: 2431 Hennepin Ave S. Minneapolis, MN 55405 Phone: 612-374-3125

| **N. I.P. Mental Health/Counseling Center<br>Fax: 612 374-3323** | | | | |
|---|---|---|---|---|
| **Patient** | Patient name | | | Previous Name |
| | Street address | | | Date of Birth |
| | City | State | ZIP code | Phone # |
| | Email address | | | |
| **These are the records I would like to release:** | **You must write your initials in front of each item you are releasing. You must write "Do Not" in front of each item you do not want released.**<br>**For dates of treatment: _____/_____ to _____/_____** *(optional)*<br>**Only records pertaining to: _____** (*optional)*<br>_____All Mental Health Records _____ Diagnostic Assessment & Summary<br>_____ Treatment Plan _____Progress Notes<br>_____ Summary _____ Closing Summary | | | |
| **For the purpose of:** | List reason for release of records (i.e. second opinion, insurance change, legal, continued care, personal, etc.) | | | |
| **Release records to:** *(Who needs your records?)* | **Self, clinic or organization:** | | | Phone # |
| | Street address (if not printed above) | | | FAX # |
| | City | State | ZIP Code | **NOTE – If records are for "self", Pick up in NIP clinic with picture ID.** |
| **Authorization and Revocation** | By completing and signing this form I authorize N.I.P. to release or obtain the information marked above. I understand I need not sign this form in order to assure treatment or payment. I understand that upon release, this health information is no longer protected by N.I.P. Community Clinic and has the potential to be re-disclosed by the recipient. I understand that I may be charged a reasonable cost based fee for my records.<br><br>Revocation: I understand that this authorization will be valid for 12 months from the date signed to release any records created up to the date of signature. Any records created after the date of this authorization will require a new authorization. I understand that I may cancel this authorization, by sending a written request for cancellation to N.I.P. Community Clinic, and that the cancellation will take effect when N.I.P. Community Clinic receives my written notice. | | | |
| | **Patient signature** | | | **Date** |
| | If other than patient, state relationship and reason patient unable to sign | | | |