THE CALLI INSTITUTE
a balanced approach to mental health

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AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT PROTECTED HEALTH INFORMATION

Patient Information

Name: _____Date of Birth: _____

Address: _____
Street City State/Zip

Phone: _____ Provider Name at The Calli Institute: _____

I Authorize **The Calli Institute, LLC to**: ☐ RELEASE TO ☐ RECEIVE FROM

You can check one or both. Checking both will allow exchange between The Calli Institute and the listed party below.

Clinic/Agency/Name:_____

Address: _____
Street City State/Zip

Fax Number: _____ Phone Number: _____

PURPOSE FOR DISCLOSURE:

- ☐ For Treatment / Care Coordination
- ☐ Litigation
- ☐ Insurance Payment/Claim
- ☐ Social Security Disability
- ☐ Social Security Disability Appeal
- ☐ Other:_____

Authorization expires on: _____
If a date, event, or condition is not specified, this authorization will expire (12) months from the date I sign this form.

WHAT INFORMATION CAN BE DISCLOSED:

- ☐ Diagnostic Assessment
- ☐ Diagnostic Assessment & last 3 progress notes
- ☐ Appointment Information
- ☐ Recent Discharge Summary
- ☐ Verbal Consultation – Exchange
- ☐ Psychological Testing Interpretive Report
- ☐ Lab results
- ☐ Billing Statement
- ☐ All records dated _____ to _____
- ☐ Any/All Medical Records *(Entire Record Can be Sent)*

I understand that:
- I may revoke this authorization at any time by notifying, in writing, the facility listed above.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or copy the health information to be disclosed.
- Information that goes to a health care provider or health plan covered by federal privacy laws will be protected by federal privacy laws.
- The Calli Institute cannot re-disclose any information from other persons or entities as protected by state or federal laws.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for third party, such as insurance companies.
- A fee may be charged for retrieval and copying of records according to MN 144.335 and Federal Rule 164.521.

_____ _____
Signature of Patient or Patient's Representative *Date*