The Calli Institute
a balanced approach to mental health

11334 86th Ave North
Maple Grove, MN 55369
Ph: 763.255.2125 | Fax: 763.255.2126
Email – info@calliinstitute.com
www.calliinstitute.com

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 to **RECEIVE information FROM:**
☐ I authorize The Calli Institute to **RELEASE information TO:**

Checking both will allow exchange between The Calli Institute and the listed party

Clinic/Agency/Name: _____

Address: _____
Street City State/Zip

Fax Number: _____ Phone Number: _____

PURPOSE OF DISCLOSURE:

☐ Continuity of Care / Care Coordination ☐ Client Request ☐ Legal/Attorney ☐ Other: _____

WHAT INFORMATION CAN BE DISCLOSED:

☐ Mental Health Intake / Assessment
☐ Mental Health progress notes
☐ Recent Mental Health Discharge Summary
☐ Psychological Testing Interpretive Report
☐ Lab Results
☐ Appointment Information
☐ Verbal Consultation – Exchange
☐ Billing Statement
☐ All records dated _____ to _____
☐ Any/All Medical Records (Entire Record can be sent)

☐ Other (please describe) _____
_____
_____

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.

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 understand that when information is released to an authorized third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy 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*