



Full Circle Therapy  
2500 McAndrews Road #230  
Burnsville, MN 55379  
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### Authorization for Release of Information

This form when completed and signed, authorizes the release and/or exchange of protected information from your clinical record to the person(s) designated.

I \_\_\_\_\_ Birthdate \_\_\_\_\_ authorize \_\_\_\_\_  
@Full Circle Therapy to release and/or exchange the following types of information:

<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Case Notes	<input type="checkbox"/> Psychological Testing and Evaluations
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Educational Assessments
<input type="checkbox"/> Summary of Treatment	<input type="checkbox"/> Chemical Dependency Evaluation
<input type="checkbox"/> Other (specify) _____	

This information will be released and/or exchanged with:

Individual and Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

This authorization will expire:

Immediately after the requested information is received

30 days after termination of treatment

Other \_\_\_\_\_

- *You have the right to revoke this authorization, in writing to Full Circle Therapy, at anytime. However, your revocation will not be effective on action already taken.*
- *Your therapist may not in general, condition the providing of therapy upon your signing an authorization, unless the services are being provided to you for the purpose of creating health information for a third party (i.e. insurance).*
- *The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPPA privacy rules.*
- *If this authorization is signed by a personal representative of the client, a description of such representatives authority to act on behalf of the client must be provided.*

\_\_\_\_\_  
Signature of Client and Guardian for Minor

\_\_\_\_\_  
Date