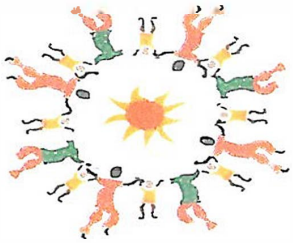

Full Circle Therapy
1500 McAndrews Road #230
Burnsville, MN 55379
PH 952-892-8404 Fax 952-892-1722

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:

__Initial Assessment
__Case Notes
__Consultation Reports
__Summary of Treatment
__Other (specifiy)_____
__Treatment Plan
__Psychological Testing and Evaluations
__Educational Assessments
__Chemical Dependency Evaluation

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