Rural Behavioral Health Clinic

Made possible by MN

Rural Behavioral Health Clinic
Made Possible by Blue Cross® and Blue Shield® of Minnesota
1600 Warren St., Ste. 6, Mankato MN 56001
507.389.1443 (P) | 855.360.3593 (F)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Blue Cross® and Blue Shield® of Minnesota Rural Behavioral Health Clinic at Minnesota State University, Mankato
1600 Warren Street, Suite 6
Mankato, MN 56001
507-389-1443 (p)

Name: _____ Birthdate: _____
Last First MI

Address: _____
Street City State Zip Code

I authorize _____ and/or Blue Cross® and Blue Shield® of Minnesota Rural Behavioral Health Clinic at Minnesota State University, Mankato administrative staff to:

☐ disclose to: ☐ obtain from: ☐ exchange with:

Name/Organization:_____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

Email: _____

Information may include medical, psychiatric, mental health, counseling, and/or alcohol and drug abuse records and information. *You have the right to restrict the disclosure of any of the types of information.*

Information to be Released:

☐ Diagnostic Assessment/Psychiatric Evaluation
☐ Psychological Testing Results
☐ Other
☐ Treatment Plan
☐ Discharge/Termination (Treatment) Summary
☐ Records Received from Past Providers

☐ Psychotherapy Notes: *with my signature below, I hereby authorize release of Psychotherapy Notes to the agency and/or individuals above.*

Purpose of this Disclosure:

☐ Coordination of Treatment ☐ Continuity of Care ☐ Consultation ☐ Other: _____

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Method of Release:

☐ Verbal discussion (in person or phone) ☐ Written documentation (copies or summary)
☐ Fax transmission ☐ Secure email (encrypted)
☐ Electronic health record portal (if applicable) ☐ Other: _____

The clinic will use secure and compliant methods to protect your privacy; however, you are advised that electronic communications carry some risk of unauthorized access.

The information disclosed shall only include the period of time from (date): _____ to (date): _____

I understand that:

- This authorization shall be valid for one calendar year from the date of my signature below.
- I agree to have information sent by mail.
- I may withdraw this authorization at any time by notifying the Blue Cross® and Blue Shield® of Minnesota Rural Behavioral Health Clinic at Minnesota State University, Mankato.
- Information disclosed by this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by the HIPAA privacy rule.
- I have the right to refuse to sign this authorization and that refusal will not condition, but may affect my treatment.
- I have the right to inspect the information I have authorized to be disclosed.
- I have the right to a photocopy of this signed authorization, and a photocopy of this form shall be as valid as the original.
- Health information may contain information regard chemical use history and AIDS.

With my signature below, I hereby state that I fully understand and agree to the terms of this release.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Printed Name of Client/Legal Representative Relationship to Client (If Applicable)

_____ _____
Witness/Provider Signature Date