



# POR Emotional Wellness

Client Name (Last, First, Middle Initial) \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Day Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

INFORMATION RELEASED FROM				INFORMATION RELEASED TO BE EXCHANGED WITH			
Name (Agency / Individual)				Name (Agency / Individual) POR, LLC			
Street Address				Street Address 8421 Wayzata Boulevard Suite 250			
City	State	Zip		City	State	Zip	
Telephone # _____ Fax # _____				Telephone # _____ Clinical Fax # _____ (952) 835-6540 (651) 925-0089			

### AUTHORIZATION TO DISCLOSE MEDICAL/BILLING INFORMATION IS LIMITED TO THE FOLLOWING:

- Admission / Intake Summary
- Discharge Summary
- Diagnostic Verification Form
- Other \_\_\_\_\_
- Diagnosis & Progress Notes
- Progress Review
- Communication to support treatment
- Chemical Dependency / Drug Alcohol Abuse Treatment Records
- Most recent Diagnostic Assessment

-OR-

- The entire record, *excluding* billing records
- The entire record, *including* billing records

### THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

- Insurance Application
- Insurance Payment
- Continuing Care
- Litigation
- Other \_\_\_\_\_

### NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for Information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. POR, LLC will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that POR, LLC cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, POR, LLC is released from any and all liability resulting from re-disclosure.

Client / Legal Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

If you are the client's legal representative please attach a copy of the document that gives you the authority to act as the legal representative. You are entitled to a copy of this document.