



Release of Information

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		City		State	
Zip				Golden Valley, MN 55426		Zip	
Telephone #		Fax #		Telephone # (952) 835-6540		Clinical Fax # (651) 925-0089	

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

- Admission / Intake Summary
 Diagnosis & Progress Notes
 Chemical Dependency / Drug Alcohol Abuse Treatment Records
 Discharge Summary
 Progress Review
 Psychological Assessment Results
 Billing Records / Statement _____
 Other _____

-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.