Terri Ross Family Connections, LLC
Terri Ross LMFT
416 Heritage Place
Faribault, MN 55021

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name_____ First Name _____MI ___
DOB____/____/_____Client address:_____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize Terri Ross Family Connections to release and/or exchange the information stated below or to receive information from my mental health record from the person/facility stated below

Information to be Released and/or Received:

□ My entire mental health record
□ Authorization for Psychotherapy Notes ONLY
□ Authorization for Diagnostic Assessment ONLY
□ Other: _____

Name of person/facility to exchange medical information with Terri Ross Family Connections :

_____

Phone: _____ FAX: _____

Address: _____
Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

Purpose of Information Release:

□ Coordination of mental health care
□ Legal investigation
□ At the request of the individual

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

_____ _____
Signature **Date**

If signed by a personal representative: Indicate your relationship to the client and legal authority for

_____
Printed Name **Relationship/legal authority**

_____
Signature **Date**

www.terrirossfamilyconnections.com
info@terrirossfamilyconnections.com
507 330-4688