1420 N. State Street
Fairmont, MN 56031
Phone: (507) 235-6070
Fax: (507) 235-6074

Authorization for Release of Information

I,____ ______________________________

Name of Client | Date of Birth

____ ______________________________

Address | Social Security Number - Optional

____ ______________________________

City, State, Zip | Phone Number

authorize Eunoia Family Resource Center, 1420 N. State Street, Fairmont, MN 56031 to disclose to and receive information from:

____

Name of Individual and Organization Name, if Applicable

____ ______________________________

Address | Phone Number

____

City, State, Zip

The following information relates to my treatment:

_____Treatment/Discharge Summary | _____Progress Notes | _____Assessment/Evaluation
_____Psychological Testing | _____History and Physical Exam | _____Lab Results
_____Family Questionnaire | _____Treatment Plans | _____Other (Specify)

____

The information is needed for the following purpose(s):____

____

Date Needed By: ______________________

Client Restrictions on Methods for Disclosure:
I understand that communication of the items to be obtained or disclosed can occur:

_____Verbally | _____In-person Conference | _____Written Questionnaire
_____Pick Up | _____Mailed Correspondence | _____Faxed Correspondence

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. Unless this form is previously revoked in writing, this release of information will remain in force until one (1) year from date of signature.

____ ______________________________

Signature of Client or Parent/Guardian When Necessary | Date

____ ______________________________

Relationship to Client | Date

____ ______________________________

Witness | Date