COMPLEMENTARY SUPPORT SERVICES

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I,_____(print name of client or guardian of the client), **authorize:**

AGENCY/ORGINIZATION:_____
(If individual is requesting information, put individuals full name)

ADDRESS:_____ **PHONE**:_____

_____ **FAX**:_____

_____ **EMAIL**:_____

To disclose and share information from/to:

Agency: Complementary Support Services (CSS)
6701 Penn Ave. South, Suite 301
Richfield, MN 55423
(952) 895-1730 (Phone)
(612) 861-7589 (Fax)

The following information:
(check all that apply)

_____ Presence in treatment (verification of intake and discharge dates)

_____ Diagnosis

_____ Intake and assessment (including medical history)

_____ Progress Notes

_____ Treatment Plan

_____ Discharge Summary

_____ Education/school records

_____ Other (specify):_____

For the purpose of:

_____ Treatment/service planning

(over)

_____ Ongoing treatment

_____ Insurance/benefit/funding source approval

_____ Other (specify):_____

_____

Preferred method of receiving confidential information: (please select one) **Fax Email US Mail**

By this release, I am <u>not</u> giving permission for the receiver of this information to re-disclose this information to any third party. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent at anytime and that in any event this consent expires automatically one year from the date below. I understand that this information may be transmitted via email.

_____ _____

Individual Receiving Services Signature **Date**

_____ _____

Legal Guardian Signature **Date**