3460 Washington Dr. Suite 110 Eagan, MN 55122 ♦ Phone (651) 688-4088 ♦ Fax (844) 700-2814 ♦ www.cedarvalleytherapy.com

Authorization for the Release of Information

I authorize appropriate staff at Cedar Valley Center for Child & Family Therapy to seek and/or release mine or my child's information.

Client information

Client name	Date of Birth

Seek and/or release to

Name
Address
Phone/Fax/Email

Information to be released	**Purpose of release**
☐ All records and ongoing communication ☐ Diagnostic reports ☐ Treatment plans/summary ☐ Progress reports ☐ Medical records ☐ Chemical health ☐ Legal records ☐ School records ☐ Social services ☐ Testing results/Psychiatric evaluations/Psychological assessments ☐ Other:	☐ Coordination of care ☐ Consultation with provider ☐ Treatment planning ☐ Transfer of care ☐ Other:

Information to be released by ☐ Verbal ☐ Written ☐ Fax ☐ Email

This authorization lasts for one year after the date signed unless indicated otherwise. This authorization may be canceled in writing at any time. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

Client/Guardian Signature	Date
Clinician Signature	Date