reimanncounselingclinic

Reimann Counseling Clinic, PLLC
7365 Kirkwood Court
Suite 360
Maple Grove, MN 55369
763-424-9591

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize Reimann Counseling Clinic to

☐ release healthcare information of the patient to the following
☐ obtain healthcare information of the patient from the following

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Reimann Therapist Signature: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.