Consent for Release/Exchange of Information

Client Information

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____

HealthCare Provider

HopeAllianz Inc and Dr Jody L Friesen Grande
4205 Lancaster Lane North, Plymouth MN 55441
Phone: 763 546 6624
Fax: 763 322 5006
Email: jodygrande@hopeallianz.com

Community Family HealthCare Provider

Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Fax _____
Email _____
Relationship _____

Information to Be Released Or Exchanged

□ Intake and History
□ Diagnosis and Treatment Plan
□ Psychological Tests
□ Treatment Progress
□ Discharge Summary
□ Billing and Payment
□ Other _____

□ Family
□ Emergency Contact

□ Verbal
□ Written
□ Email

Purpose of Release

□ Coordination of care
□ Transfer of care
□ Other _____

□ Family
□ Emergency Contact

I understand that I may revoke this authorization, in writing, at any time and that upon fulfillment of the above stated purpose, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

_____ _____
Client Signature Date