



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
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Community Family HealthCare Provider Name _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Fax _____
Email _____
Relationship _____

Information to Be Released Or Exchanged

<input type="checkbox"/> Intake and History	<input type="checkbox"/> Family
<input type="checkbox"/> Diagnosis and Treatment Plan	<input type="checkbox"/> Emergency Contact
<input type="checkbox"/> Psychological Tests	
<input type="checkbox"/> Treatment Progress	<input type="checkbox"/> Verbal
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Written
<input type="checkbox"/> Billing and Payment	<input type="checkbox"/> Email
<input type="checkbox"/> Other _____	

Purpose of Release

<input type="checkbox"/> Coordination of care	<input type="checkbox"/> Family
<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Emergency Contact
<input type="checkbox"/> Other _____	

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