PEOPLES DEVELOPMENT SERVICES
St. Paul Office: 665 Snelling Ave N, St Paul, MN 55104
Minneapolis Office: 3617 E. Lake Street Ste A-3, Minneapolis, MN 55406
Phone: 612-332-9124 Fax: 612-332-9867 Email: contact@pdsminn.org
www.pdsminn.org

Authorization For Release of Medical Information

Client Name:_____ Date of Birth:_____/_____/_____

Clinic Name:_____ Clinic Fax:_____

I authorize Peoples Development Services (PDS) to exchange with clinic:_____

I (Client Name)_____authorize PDS to release and exchange (both releasing and obtaining) of the following protected health information:

Information to be released:
____Medical History/Summary
____Medical Reports
____Assessment/Diagnostic Findings
____Psychiatric Evaluation
____Discharge Summary
____Chemical Dependency History/Assessment Reports & Treatment Records
____Progress Notes
____Education/School Records
____Medical Treatment Plan
____Other: _____

Purpose of releasing information:
____Continuing Care
____Behavioral Health Treatment
____Client Request
____Coordination of Services
____Social Security Income or Benefits

This consent expires automatically twelve (12) months from the date this consent is signed, unless revoked by me.
I understand that I may cancel this authorization at any time. To cancel this authorization, I must notify PDS in writing. This authorization will be canceled once PDS has received my written notice. The expectation to this would be if would be if my information has already been released prior to me signing this authorization. In that case, this information would not have been protected by federal privacy regulation.

_____ _____/_____/_____ _____
Client Signature Date Parent/Legal Guardian