THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE ● Pine City, MN 55063 ● (320) 629-7600 ● Depot Fax (320) 629-7900 ● Hilltop Fax (320) 629-0003

AUTHORIZATION FOR THE RELEASE / EXCHANGE OF INFORMATION

Client Name	Date of Birth	County	
Street Address	City	State	Zip Code

Legal Parent or Guardian (Print Name): _____

Address _____ City/State/Zip _____

Relationship _____Phone Number _____

I authorize **Therapeutic Services Agency, Inc.** to release/exchange to/with information to the following listed below:

Information will be released by: Fax, Phone, In-Person, Email and Mail (unless crossed off)

I am agreeing to release/exchange information to: ⟶								

Check (✔) all that are applicable:

All materials in records								
Medical history and treatment								
Psychosocial history								
Assessment and diagnosis								
Progress Notes and Treatment Plans								
Juvenile Court Records								
Medication and treatment records								
Summary of psychological testing								
Discharge summary								
Financial and Health Insurance Data								
Only in an emergency								
Educational/School Records								
Other: _____								

- **I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.**
- **I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidality, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.**
- **I understand that the information or records listed above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited.**
- **I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below**.

This authorization automatically expires, unless otherwise provided by state law, on (specific date) : _____
1 year from date of signature below

_____ _____ _____
Signature of Patient/Legal Guardian Relationship to Patient (if applicable) Date

_____ _____
Signature of Minor Patient Date

_____ _____
Signature of Witness / Requestor of Information Date