AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Fuller Living & Associates, LLC(2006 1st Ave N STE 206, Anoka, MN 55303, 763-647-8188) to:
___disclose information to ___obtain information from
___exchange information with ___notify physician

_____ _____
(Name of Person) (Name of Agency)

_____
(Address)

_____ _____
(City) (State) (Zip)
Fax # _____
Phone # _____
Regarding: _____ _____
(Client Name) (Date of Birth)

_____
(Address)
_____ myself _____ my daughter/son _____ other: _____
The information to be disclosed is:
_____ Discharge/treatment summary _____ Admission/Intake Summary
_____ Progress notes _____ Diagnostic Impressions
_____ Academic records/school functioning _____ Chemical Dependency Evaluation
_____ Psychological testing _____ Medical history & physical exam
_____ Social/Court Services Summary _____ Medication history
_____ Other _____

I understand that my records are protected by the Data Privacy regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations, and that I may revoke the consent at any time. I understand that this consent will automatically expire without my express revocation upon fulfillment of the above stated purpose or one year from this date, whichever is sooner. I have the right to receive a copy or review information to be disclosed, if requested.

_____ DATE:_____
Signature of client

_____
Signature of parent/guardian (if minor) _____

Person informing client of rights, Signature:_____DATE:_____
This release expires on:_____