

Client Name (Last, first, middle initial)		Social Security #:	
Street Address	City	State	Zip
Date of Birth	Day Phone#	Evening Phone #	

INFORMATION RELEASED TO/EXCHANGED WITH INFORMATION RELEASED TO/EXCHANGED WITH

Name of Staff Member or Department	
Facility Name and Address Volunteers of America Avanti Center for Girls	
10300 Flanders St NE	
Blaine, MN 55449	
Phone: 763.230.7470	Fax: 888.972.8981

Name:		
Street Address		
City	State	Zip
Date Information Needed:		
Phone:	Fax:	

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

- Diagnostic Assessment
 Clinical Intake
 Progress Notes
 Testing Results
 Discharge Summary
 Treatment Plan/Review
 All Mental Health Records
 Health History/Current Status
 Current Medications
 Daily Functional/Behavioral Independence

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

- Patient Access
 Insurance Application
 Social Security Disability Determination
 Litigation
 Social Security Disability Appeal
 Continuing Care
 Insurance Payment

Other (specify) _____

Authorization expiration date or event: _____ (if left blank, will expire one year from date of signature)

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. A photocopy/fax of this authorization will be treated in the same manner as an original.

Further, I realize that VOA Avanti cannot prevent the redisclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore the VOA Avanti is released from any and all liability resulting from redisclosure. I have read and understand my rights as described on the back side of this form.

Patient/Legal Representative Signature Date

Authority to act on behalf of Patient (attach document)