Volunteers of America
Minnesota

Children's Residential Treatment Center
Minneapolis, MN
612-870-4300

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

INFORMATION RELEASED TO/EXCHANGED WITH

Name of Staff Member or Department	
Facility Name and Address VOA Children's Residential Treatment Center	
143 E. 19th Street	
Minneapolis, MN 55403	
Phone: 612-870-4300	Fax: 888-965-5129

INFORMATION RELEASED TO/EXCHANGED WITH

Name of Staff Member or Department	
Facility Name and Address	
Phone:	Fax:

PLEASE INDICATE THE INFORMATION TO BE DISCLOSED:

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

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

☐ Patient Access ☐ Insurance Application ☐ Social Security Disability Determination ☐ Litigation ☐ Social Security Disability Appeal
X 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 CRTC 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 CRTC 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