Volunteers of America
MINNESOTA AND WISCONSIN

Avanti ◆ Bar None ◆ Children's Residential Treatment Center ◆ Omegon

Authorization to Release or Exchange Protected Health Information

Resident Name: _____ Birth Date: _____

I authorize the following information from the records of the above-named resident to be:

☐ Released to VOA ☐ Released by VOA

Information to be released to or exchanged from VOA-MNWI, Youth Residential Treatment Programs:

Children's Residential Treatment Center: 143 E 19th Street, Minneapolis, MN 55403, P: 612-870-4300 F: 888-965-5129
Avanti: 10300 Flanders Street NE, Blaine, MN 55449, P: 763-230-7470, F: 888-972-8981
Omegon Residential Treatment Center: 2000 Hopkins Crossroad, Hopkins, MN 55305, P: 952-541-4738 F:888-965-5128
Bar None: 22426 St. Francis Blvd, Anoka, MN 55303, P:763-753-2500, F: 888-965-5125

Information to be released to or exchanged with:

Individual: _____

Program: _____

Address: _____ Phone Number:_____

Fax: _____ Relationship to Resident: _____

The information to be disclosed is:

☐ Social and drug history
☐ Psychological testing (IQ, MMPI, Shipley, etc)
☐ Psychiatric and Mental Health Information
☐ Discharge and prognosis summaries
☐ Physical Exam/Nurse's Discharge Notes
☐ School records
☐ Weekly Updates
☐ Phone contact
☐ County Case Plan Goals
☐ Immunization Records
☐ All LABS for medication(s) – (i.e.: fasting lab results, etc.)
☐ Chemical Dependency and Use information including prognosis and VI Dimensions
☐ Medical Information (to include prior three-year history)
☐ HIV/Aids related testing and/or treatment
☐ Other (specify):

The records are for the following time period or condition: _____
This information is needed for the following purpose(s):

☐ Continuity of care ☐ Insurance claims ☐ Personal use
☐ Other (specify):

I understand what information will be released, the purpose of releasing the information, who will receive the information, and the known consequences of releasing the information. I have been informed of my right to refuse to release the information and the known consequences of not releasing it. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that I may revoke the consent at any time with written notice. I understand the consent may not be revoked retroactively. **This consent will automatically expire one (1) year after the date of my signature if it has not previously been revoked, and/or one month after date of client discharge.** I do not authorize further release by the information's recipient to any third party. I understand there may be a charge for the retrieval and/or photocopying of these records. I understand that a photocopy or fax of this form is the same as the original.

_____ _____
Resident Signature Date

_____ _____
Parent/Guardian/Legal Representative (specify relationship) Date