

**Bluestem Center**  
124 Elton Hills Lane NW  
Rochester, MN 55901

Phone: 507-282-1009; Fax: 507-282-0932

**AUTHORIZATION for RELEASE OF CONFIDENTIAL INFORMATION**

Client Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First M.I. (maiden)

Client's Address: \_\_\_\_\_  
(street, city, state, zip)

I hereby authorize Bluestem Center to: \_\_\_ exchange with or \_\_\_ disclose to or \_\_\_ obtain from:

Agency and/or Individual's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(street, city, state, zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**MENTAL HEALTH, CHEMICAL DEPENDENCY OR OTHER  
HEALTH INFORMATION FOR THE TIME PERIOD OF:**

From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_; including the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diagnostic Assessment  | <input type="checkbox"/> Therapy/Counseling Notes                               | <input type="checkbox"/> Medication History    |
| <input type="checkbox"/> IEP/School Assessment  | <input type="checkbox"/> Psychological Evaluation                               | <input type="checkbox"/> Discharge Summary     |
| <input type="checkbox"/> Laboratory Reports     | <input type="checkbox"/> Psychiatric Assessment                                 | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Labor & Delivery Notes | <input type="checkbox"/> Academic Records/School Functioning/Attendance History |  |
| <input type="checkbox"/> Other (specify): _____ |   |  |

**FOR THE FOLLOWING PURPOSE(S):**

- Coordination of Care       At the Request of the Individual or Guardian
- Continuation of Care and Treatment Planning from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
- Court or other Legal Request       Other: \_\_\_\_\_

*I understand that I may revoke this consent in writing at any time, as explained in Bluestem Center's Notice of Privacy Practices. This authorization will automatically expire, without my expressed revocation, one year from the date of signature. I also understand that any disclosure or use hereby authorized cannot be made to anyone other than the facility or individual listed above, unless I provide such authorization, or in case of emergency. I understand all of the aforementioned and, with informed consent and of my own free will, I authorize disclosure of protected health information.*

\_\_\_\_\_  
Signature of client; parent or legal guardian (note relationship if guardian)

\_\_\_\_\_  
Signature of client if age 16-17

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date