



Direct: 651- 408-3174

debranelson@beyondthebraintherapies.com

Fax: 651- 464-2289

RELEASE OF INFORMATION

I am requesting that share information regarding (**client name**) with Debra Nelson, MA LMFT or the Consultants at CMS /BTBT. I am of a sound capacity and have legal authority to make this agreement for myself or as the guardian of

Client Name **Birth Date:**

Guardian Name: **Phone Number:**

Company whom client is asking us to receive, exchange or release information with:

Organization:

Specific Person:

Address:

Phone: Fax:

Email:

Please make a note of any exceptions to information requested:

I understand that this information will be disclosed to the above person, organization or agency from records who confidentiality is protected by Federal Laws and State Statutes. I also understand that I may revoke this authorization at any time by giving notice in writing, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise limited, this authorization will expire one year from the date of signing. I understand that this information will be used or disclosed pursuant to the authorization and subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Rule. Lastly, I agree to the transmission of electronic devices for the purpose of expediting services when that is necessary.

Please send these records to Debra Nelson, MA LMFT at 407 West Broadway St, Forest Lake, MN 55025 or fax to 651-464-2289 Call 651-408-3174 or email debranelson@beyondthebraintherapies.com Thank you!

Signature: _____

Date: _____

