Release of Information

Client Information

Client Name | Date of Birth (DOB)

Street Address | E-Mail Address

City | State | Zip Code | Phone Number

Releasing Party

Party Name

Street Address | E-Mail Address | Fax Number

City | State | Zip Code | Phone Number

Receiving Party

Horowitz Health (HH)

Party Name

1295 Northland Dr., Ste. 270 | Admissions@horowitzhealth.com | (651) 448-2147

Street Address | E-Mail Address | Fax Number

Mendota Heights | MN | 55120 | (651) 728-9147

City | State | Zip Code | Phone Number

Release Purpose

- ☑ Continuing Care
- ☐ Insurance
- ☐ Other:
- ☐ Personal Use
- ☐ Social Security
- ☐ Legal
- ☐ Disability

Pursuant to Minn. Stat. § 144.294 and 45 CFR § 164.524, fees may be charged for release of documentation.

Information to be Released

I want my records related to:

I want my records for the following dates:

Individual Options

- ☐ Diagnostic Assessment
- ☐ Health History
- ☐ Functional Assessment
- ☐ Everything
- ☐ Individual Encounters
- ☐ Group Encounters
- ☐ Intake Forms
- ☐ Individual Abuse Prevention Plan
- ☐ Treatment Plan
- ☐ Locus of Care Assessment
- ☐ Immediate Needs Assessment

Method of Release

Date records are needed:

Individual Options

- ☐ Secure E-Mail
- ☐ U.S. Mail
- ☐ Non-Secure E-mail (i.e., Client Only)
- ☐ Pick-Up
- ☐ Fax

Acknowledgement and Authorization

By signing this form, I authorize the release of my protected health information (PHI) to- and from- any IRTS facility currently operated or later opened by HH, for the purposes of determining clinical fit, coordinating placement, admission, treatment, and continuity of care. A list of facilities is available to me upon request. This authorization is valid for one (1) year from the date signed unless a different expiration is specified. I may revoke this authorization in writing at any time, but any disclosures made before revocation remain valid. Refusal to sign will not impact my access to treatment. Copies or faxes of this form are valid as originals. My records may include information from other providers, which may be re-disclosed if integrated into my HH file. Once released, information may not remain protected under state or federal privacy laws, and HH is not responsible for further disclosure. SUD information is protected under 42 CFR Part 2 and may not be shared without your explicit consent. My signature confirms that I understand and agree to the terms of this release.

Client or Representative Signature | Date