Quality Life / D & L, P.C.
1316 23rd street South
Fargo ND 58/102
Office: (701)-478-0333 Fax: (701)-478-0434

AUTHORIZATION FOR RELEASE OF CLINICAL INFORMATION

Name of Clients: ___________________________________ **Date of Birth:** ________________________

I, the undersigned, hereby authorize Quality Life/D&L, P.C. to: ☐ **Disclose to** ☐ **Obtain from** ☐ **Exchange With**

Name of Organization: ____

Address: ____ City: ______________________ State: ______

Zipcode: ____________ Phone: ____________________ Fax: ____________________
Dates of documentation being requested [] All Available [] Info from _______________ To _____________

	Diagnosis		Admit/Discharge Dates & Reports		History of Trauma/Injury
	Diagnostic Assessment		Progress Reports		Emergency Notification Info.
	Psychiatric Evaluation		Medications		Family Involvement Info.
	Psychological Assessment & Testing		Laboratory Results		School Reports/ IEP
	CD Assessment		Recommendations		Verbal Only
	Other: (Specify)				

The information is necessary for:

	Diagnosis & Treatment		Coordination & Follow-up		Family Involvement
	Acknowledge Referral		Insurance Purposes		Education Purposes
	Legal		Personal Record		Emergency Notification
	Update Record		SSP Participation		On-Site Chart Review
	Other: (Specify)				

Revocation & Expiration of Consent:
This consent will expire upon fulfillment of its stated purpose or one year from date of signature. I understand that I may revoke this consent to release information by written notice or any time except (1) when legal action prevents revocation (probation, parole, court confinement or (2) when requested by my insurance company, as the law provides my insurer the right to contest a claim under my policy. Any release made in good faith, prior to receipt of revocation , shall be deemed valid. A photocopy of this authorization may be treated in the same manner as the original, however, D&L, Inc., reserves the right to require an original consent. I understand the protected health information used or disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

I do not need to sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party (i.e. consultation).
This release of information will be accepted only if all items have been completed.
A fee may be assessed for the requested records.
Requested information may be released directly to the person, or by mail, phone or fax.
Do not release records regarding [] psychiatric mental health [] Chemical dependency [] HIV aids related information

Clients Signature: ____ Date: __________________________

Parent/Guardian Signature: ____ Date: __________________________

Witness Signature: ____ Date: __________________________

If the client is unable to sign the person signing the authorization will be required to show proof of guardianship or other authority and the relationship to client, allowing him/her to authorize the release of information.
kmm 09/2007

Information Released

This notification was mailed/faxed to: ____

☐ Mailed ☐ Faxed

Date ______________ Medical Records Personnel (Initial) ______________

This notification was mailed/faxed to: ____

☐ Mailed ☐ Faxed

Date ______________ Medical Records Personnel (Initial) ______________