Shady Oak Counseling, LLC
6542 Regency Lane, Suite 205
Eden Prairie, MN 55344
Office: 952.356.6526
Fax: 952.903.9257

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:		Date Of Birth:
Address:	City, State, Zip:	Phone:

I authorize the disclosure of information: ☐ **Between:** ☐ **To:** ☐ **From:**

Name/Attention: Suzanne R. May, MA, LP	Name/Attention:
Organization: Shady Oak Counseling, LLC	Organization:
Address: 6542 Regency Lane, Suite 205	Address:
City, State, Zip: Eden Prairie, MN 55344	City, State, Zip:
Phone: 952.356.6526 Fax: 952.903.9257	Phone: Fax:

Information to be disclosed:

- ☐ Diagnostic/Intake Evaluation
- ☐ Progress Notes/Treatment Summary
- ☐ Psychological Evaluation
- ☐ Summary of Treatment Services Provided
- ☐ Medical Records (including psychiatric)
- ☐ Verbal Progress Reports and Updates
- ☐ Juvenile/Adult Court Records
- ☐ Academic Records
- ☐ Psychological Testing
- ☐ Entire Treatment Record
- ☐ Chemical Dependency Assessment
- ☐ Chemical Dependency Treatment Records
- ☐ Other (Specify) _____

This information is being obtained/released for the purpose of:

_____

I understand that this authorization permits the release of information between Suzanne R. May, MA, LP of Shady Oak Counseling, LLC and the specified individual/agency. I understand I need not sign this form in order to assure treatment or payment. I understand that upon release, this health information is no longer protected by Shady Oak Counseling, LLC and has the potential to be redisclosed by the recipient. **I understand there may be a charge for my records per Minnesota Statute 144.335**. I understand that a photocopy of this release shall be as effective for this purpose as the original. I understand that this authorization will be in effect for 12 months from the date signed unless cancelled by me in writing and that the cancellation will take effect when the provider receives my notice in writing.

_____ _____

Client Signature Date