6775 Cahill Avenue, Inver Grove Heights, MN 55076
Office:651-999-3537 Fax: 651-305-0193

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION

A copy of this will be considered as valid as the original

Name: ________________________________ Date of Birth:_____________________ Phone: __________________________

I authorize Gateway Recovery Center, LLC ("GRC") and the party listed below to exchange written and/or oral information that is personal and confidential to me, including without limitation, the information identified in this Authorization:

____From GRC to the party listed below
____From the party listed below to GRC
____Two way release allowing both GRC and the party listed below to share information with each other

Name of Organization or Person: _______________________________________ Relationship to Guest: ___________________________________

Address (City, State, and Zip Code): ____

Phone: __________________________ Fax: _______________________________

The private health information I am authorizing to be shared includes:

____ Summary of Chemical Health Treatment Services
____ Summary of Mental Health Treatment Services
____ Diagnostic Assessment
____ Treatment Plan
____ Results of Chemical Use Assessment
____ Results of Psychological Testing
____ Chemical Dependency Treatment Notes
____ Discharge Summary & Recommendations
____ Ongoing Reports on Treatment Progress
____ Results of alcohol/drug screening test
____ Relevant Medical Information
____ Billing Records
____ Psychotherapy Notes
____ Other: _______________________________________
____ All of the above

Reason(s) for releasing information:

____ Client Access
____ Treatment/Continued Care
____ Insurance Payment
____ Social Security Disability Determination
____ Social Security Disability Appeal
____ Other: ____

I understand and agree that: (a) I am requesting that the health information specified above be disclosed to the third party named above; (b) this Authorization is voluntary and that if the individual or organization authorized to receive this information is not a covered entity under federal privacy regulations, the release of my individually identifiable health information may no longer be protected by federal privacy regulations; (c) once this information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient(s) and may no longer be protected; (d) this Authorization may be revoked by me at any time by a written instrument signed by me and delivered by mail to GRC; (e) if I revoke this Authorization, the revocation will not apply to any medical information previously disclosed or have any effect on actions previously taken by GRC before it receives a copy of the revocation of this Authorization; (f) this Authorization will expire one year after date of signature, unless I specify a date here: ______________________; (g) receiving services from GRC in the form of medical care, procedures, supportive counselling, treatments and related services is not conditioned on whether I sign this Authorization; and (g) that in light of these understandings, I release GRC and its affiliates, directors, officers, owners, and employees and successors and assigns from any and all liability directly or indirectly resulting from disclosure of information by GRC or subsequent re-disclosures of the information pursuant to this Authorization. I further agree and understand that I will indemnify and hold harmless GRC and its affiliates, directors, officers, owners, and employees and successors and assigns of any of the foregoing from and against any and all liabilities or damages, including reasonable attorneys' fees and costs, incurred by any person or entity as a result of any third party claims, arising from or occurring as a result of the disclosure of my information by GRC.

With these understandings in mind, I now voluntarily authorize the use and disclosure of my individually identifiable health information and other information as described in this Authorization.

____ ________________________________
Signature of Patient or Patient's Legal Representative & Title Date