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Name of Client: _____ DOB: _____

Street Address: _____

authorize **000se 00000** of the following information from my records: **(please check all that apply)**

- | | |
|--|--|
| <input type="checkbox"/> School Achievement, Behavior, and Educational Records | <input type="checkbox"/> Chemical Dependency Treatment/Evaluation Records |
| <input type="checkbox"/> Court Documents/Investigations/Letters and Reports/Affidavits | <input type="checkbox"/> Psychiatric Evaluation and Medication Management Records |
| <input type="checkbox"/> Legal/Police Records & Incidents Reports | <input type="checkbox"/> Psychological Test Scores/Profiles |
| <input type="checkbox"/> Child Abuse/Neglect Assessment Reports | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Summary of Social History | <input type="checkbox"/> Progress Reports and Treatment Plans |
| <input type="checkbox"/> Discharge Treatment Summaries | <input type="checkbox"/> Medical Records (including info on HIV/AIDS & Sickle Cell Anemia) |
| <input type="checkbox"/> Verbal Communication | <input type="checkbox"/> All of the above Materials in Record |

Other: _____

This information is needed for treatment planning and case coordination.

This consent will expire within one year from the date of signature unless earlier expiration is noted here: 0 000000000000

This information will be exchanged between (to/from):

Nexus-FACTS, Families, Adolescents, and Children Therapy Services, 1385 Mendota Heights Road Suite 200, Mendota Heights, MN 55120 and:

Person and / or Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. Nexus-FACTS will not refuse or restrict my treatment if I choose not to sign this authorization. A photocopy/fax of this authorization will be treated in the same manner as the original.

Further, I realize that Nexus-FACTS cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore Nexus-FACTS is released from any and all liability resulting from re-disclosure from 3rd party sources.

My signature also means I have read this form and/or have had it read to me and explained in a language that I can understand.

Client Signature: (Parent or guardian if client is minor or incompetent) _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____