Stacy Nunne, MA, LMFT, SEP, RN/Hope in Healing Counseling and Wellness, LLC
600 West 78th Street, Suites 10A-C, PO Box 892, Chanhassen, MN 55317
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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Client Name: _____DOB:_____
Address:_____ Phone:_____
City_____State:_____Zip:_____

I hereby authorize the following party to release to and/or exchange information with
Stacy Nunne, MA, LMFT, SEP, RN/MN MFT License–2803/MN Nursing License–R 110685-1

Name:_____
Address:_____ Phone:_____
City_____State:_____Zip:_____
Relationship to Client: _____

The purpose of this release is for:

_____ Continuity of care
_____ Coordination of care with another treating healthcare provider
_____ Insurance plan or third-party-payer review of records for quality and level of care and/or justification of charges, and as needed to authorize more sessions or to process claims, or to fulfill administrative review by plan
_____ Personal Records
_____ Other: _____

The information released will be limited to:

Personal Health Information (PHI) to be released between Stacy Nunne, MA, LMFT, SEP, RN and the party above

Verbal	Written	(Please Initial)
_____	_____	Attendance
_____	_____	Summary of pertinent psychiatric and psychosocial history
_____	_____	Treatment summary
_____	_____	Billing Records/Information
_____	_____	Any information deemed necessary to coordinate care
_____	_____	Complete treatment records
_____	_____	Other:_____

For the following time period (Specify dates): _____
How would you like your information released? (Please circle) Mail Secure Encrypted Email Unsecure Email Pick Up at office

I understand that:

- My personal health information is protected by federal regulations and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in the HIPAA Privacy Notice and HHCW Privacy Notice and state and federal laws,
- I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws,
- I certify that information will not be used for any purpose other than its intended use and will not be re-released to another party,
- Communications resulting from this authorization will reveal that I received services from Stacy Nunne, MA, LMFT, SEP, RN/ Hope in Healing Counseling and Wellness, LLC,
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and is no longer protected by the HIPAA Privacy Rule,
- Agree that Hope in Healing Counseling and Wellness, LLC will only release information generated by Hope in Healing Counseling and Wellness, LLC. PHI that Hope in Healing Counseling and Wellness, LLC has received from other providers must be obtained through that provider, unless required by law,
- There may be a fee for reports and/or retrieval and copy charge associated with the release, Hope in Healing Counseling and Wellness, LLC will inform me of the costs,
- I understand that I have a right to a copy of this form,
- I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address, However, my revocation will not be effective to the extent that actions have already been taken in reliance on it. If not revoked earlier, this consent expires by the date specified by me or 12 months from the date signed,
- I would like this release to expire on (Date):_____(please initial).

Signature of Client:_____Date:_____