2324 University Avenue West #120
St. Paul, MN 55114-1843
651-646-3221
Fax 651-641-0452

Authorization to Disclose Protected Health Information

Name: ____________________

Address: ____________________

This form is used to ask PATH, Inc. to give out health information:

1. Who may give it out: PATH, Inc. 2324 University Avenue West #120, St. Paul, MN 55114-1843
2. Who may get and use it: (Please print name, address, phone number and relationship. (For example: spouse, adult child, parent, foster parent, stepparent, sibling, attorney, employer, domestic partner, other.)

NAME	ADDRESS / CITY / STATE / ZIP	RELATIONSHIP	PHONE #

3. What information may be given out: ____________________
4. How long this permission lasts: ____________________
   Note: If no date is given, it ends: ____________________

I understand that:

- I may revoke this permission at any time by writing to PATH, Inc. at the address in #1.
- Revoking my permission does not apply to information that has already been given out.
- An electronic or photocopy version of this form is as valid as the original.
- I have the right to see or copy the health information to be given out.
- If this information goes to a health care provider or a health plan covered by federal privacy laws, it is protected by those laws.
- Information that goes to other persons or entities may not be protected by federal privacy laws. It may be given out again. Note: drug and alcohol abuse information may be protected by federal substance abuse confidentiality laws.
- I do not have to sign this form. If I do not sign this form, PATH, Inc. cannot give out the information that I have asked to be released (above). PATH, Inc. cannot condition treatment, payment, eligibility or services on my signing this form.

____________________ ____________________
Signature of consumer or consumer's representative Date

If signed by a representative, also submit a copy of legal authorization (for example: power of attorney, guardian, foster parent, retainer).

☐ I would like a copy of this form sent to the consumer.

____________________ ____________________
Print representative's name Relationship to member

Please complete and sign this form. Send it to PATH, Inc.

Treatment Foster Care
and Family-Based Services

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St. Paul, MN 55114-1843
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