Nystrom & Associates, LTD.

Authorization for Release of Information to Primary Care Provider

Patient Name: _____ **Date of Birth:** _____

Treating Provider: _____

☐ **Send information about my initial treatment plan to my Primary Care Provider for continuing care.**
☐ **Coordinate with my Primary Care Provider as necessary for care.**
☐ **Do not send my treatment information to my Primary Care Provider.**
☐ **I do not have a Primary Care Provider.**

I authorize Nystrom & Associates, LTD. to RELEASE to and RECEIVE from:

Primary Care Provider/Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand the following: See CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization will remain valid until care is terminated with NAL or this authorization is revoked by the patient.

Patient Signature: _____ **DATE**: _____

Legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

NOTE: If signed by someone other than the patient, we need written proof of authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

TREATMENT PLAN SUMMARY
(To be completed by Provider)

Date of initial assessment: _____ Next appointment: _____

Diagnosis and / or presenting problem: _____

_____

Treatment recommendations: _____

_____

Medication (if applicable): _____

☐ Attached is a copy of the patient's initial evaluation, including their treatment plan.

For internal use: Faxed Date: _____ Initials: _____

Minneapolis/St. Paul
Brighton Professional Building
1900 Silver Lake Road, Suite 110
New Brighton, MN 55112
P (651) 628-9566
F (651) 628-0411

Apple Valley
Merchants Bank Building
7300 West 147th Street, Suite 204
Apple Valley, MN 55124
P (952) 997-3020
F (952) 997-3026

Big Lake
207 Jefferson Blvd
Big Lake, MN 55309
P (763) 367-6080
F (763) 263-7897

Bloomington
1101 E 78th Street, Suite 100
Bloomington, MN 55420
P (952) 854-5034
F (952) 854-5363

Brainerd/Baxter
13045 Falcon Drive
Suite 100
Baxter, MN 56425
P (218) 829-9307
F (218) 829-7649

Cambridge
817 N Main Street
Cambridge, MN 55008
P (763) 325-0300
F (763) 325-0301

Coon Rapids
11660 Round Lake Blvd NW
Coon Rapids, MN 55433
P (763) 767-3350
F (763) 767-0912

Duluth
Providence Building
332 West Superior Street, Suite 300
Duluth, MN 55802
P (218) 722-4379
F (218) 722-4333

Eden Prairie
Prairie Lakes Corporate Center II
11010 Prairie Lakes Drive, Suite 350
Eden Prairie, MN 55344
P (952) 746-2522
F (952) 746-0887

Elk River/Otsego
9245 Quantrelle Avenue
Otsego, MN 55330
P (763) 746-9492
F (763) 746-3685

Maple Grove
13603 80th Circle North
Maple Grove, MN 55369
P (763) 274-3120
F (763) 274-3121

Minnetonka
Riverview Office Center
13100 Wayzata Boulevard,
Suite 200
Minnetonka, MN 55305
P (952) 206-2040
F (952) 206-2041

Rochester
401 16th Street SE, Suite 100
Rochester, MN 55904
P (507) 516-0030
F (507) 516-0031

Sartell/ St. Cloud
101 Dehler Dr
Sartell, MN 56377
P (320) 253-3512
F (320) 253-1037

Woodbury
Woodbury Plaza Office Building
1811 Weir Drive, Suite 270
Woodbury, MN 55125
P (651) 714-9646
F (651) 714-9647