Release of Information and Consent Form

It is important that all members of the treatment team work together. As such, I, Ericha Rupp, MA, MT-BC, would like your permission to communication, when necessary, with your medical provider, healthcare practitioner, clinician, mental health practitioner, county case manager, social worker, and any other member of the treatment team.

Client Name:____D.O.B.________________
Address:____
City:_______________________State:_______________________Zip:_______________
Primary Phone Number:_____________________Email:____________________________

I, ____________________, hereby authorize the release and exchange of information specified below between:

____
(Name/Title or Organization Name)

____
(Person to Contact and Title)

____
(Mailing Address)

____
(Phone Number/Fax/Email Address)

And

Note-Able Music Therapy Services of MN, LLC
Attn: Ericha Rupp, MA, MT-BC
1505 Mcintosh Circle
Shakopee, MN 55379
P: 507-581-2957
E: nmtsofmn@gmail.com

This release of information shall be limited to the following specific types of information (if there are no limits please check the bottom box):

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial Evaluation
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Updates
- ☐ Medication Management Information
- ☐ Presence/Participation in Treatment
- ☐ Nursing/Medical Information
- ☐ Toxicological Reports/Drug Screening
- ☐ Educational Information
- ☐ Discharge/Transfer Summary
- ☐ Continued Care Plan
- ☐ Progress in Treatment or Notes
- ☐ Demographic Information
- ☐ Other_________________________
- ☐ Other_________________________

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:____.

This authorization for release of information is made with informed consent is subjected to revocation by written instructions of the undersigned at any time by sending notification to Ericha Rupp, MA, MT-BC in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any re-disclosure by the recipient is prohibited, unless expressly permitted by the client or someone authorized to act on his/her behalf. I understand that this author authorizes the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records.

____
Client's Name (Printed)

____ _____________
Client's Signature/Primary Caregiver Date