Stephen M. Hjemboe, Ph.D.
Licensed Psychologist
Saint Paul Psychology
2233 North Hamline Avenue, Saint Paul, MN 55113
651-776-2648 Fax: 651-778-1458

Authorization to Release and/or Request Information

I, _____ Date of birth _____/_____/_____

Street address City State Zip

Hereby do authorize _____

Name of clinic _____

Street Address _____

City, State, Zip _____

Phone/Fax _____

To ☐ Release to
☐ Exchange with
☐ Receive from Stephen M. Hjemboe, Ph.D., LP

The information checked below:

- ☐ Verbal exchange of information concerning my treatment
- ☐ Psychological evaluation
- ☐ Psychological testing
- ☐ Treatment records, including progress notes
- ☐ Treatment summary
- ☐ Other _____

For the purpose of:

- ☐ Evaluation and/or treatment
- ☐ Other_____

Restrictions requested, if any: _____

This release is valid: ☐ until receipt of information; ☐ for 6 months; ☐ until revoked.

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. If the disclosed information goes to aa health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons or entities may not be protected by state or federal laws and may be re-disclosed. I am aware that a photocopy of this release is as valid as the original.

Patient signature _____ Date: _____

Witness _____ Date: _____