VANGUARD
MENTAL HEALTH & WELLNESS CLINIC, LLC

2165 Woodlane Drive, Ste 100
Woodbury, MN 55125
Office: (651) 283-3794
Fax: (651) 738-1881
www.vanguardmhclinic.com

ACKNOWLEDGEMENT OF RECEIPT OF ALL MENTAL HEALTH RECORDS

I, _____, hereby acknowledge that at my request, copies of my/my child's otherwise confidential mental health records are being released into my possession by Vanguard Clinic.

I understand that in accepting these copies, I assume all responsibility for their disposition and safekeeping. I do not hold Vanguard Clinic liable or responsible for the content of these records.

This authorization will expire in one year, unless it is revoked.

My signature here means I have read this information and understand it.

Signature: _____ Date: _____

Print name: _____
Relationship to patient: _____

Interpreter (name/signature): _____

Patient Name: _____
Date of birth: _____