Authorization to Release Protected Health Information

This form collects information that is part of the medical record. **Route to Scanning.**

NWMHC Number	Name *(First, Middle, Last)*	Birth Date *(Month, DD, YYYY)*

Instructions: If any section is incomplete, this form may be invalid.

Release Information From:

- ☐ NWMHC 603 Bruce Street, Crookston, MN 56716
- ☐ Other *(specify facility/individual (relationship if applicable) & address below, including phone/fax if known.)*

_____

_____

Phone #:

Release Information To:

- ☐ NWMHC 603 Bruce Street, Crookston, MN 56716
- ☐ Other *(specify facility/individual (relationship if applicable) & address below, including phone/fax if known.)*

_____

_____

Phone #:

Purpose of Release

- ☐ Treatment/continued care ☐ Personal ☐ Legal Purposes ☐ Application for insurance
- ☐ Disability Determination ☐ Payment of Insurance Claim/Billing ☐ Payment of Insurance Claim
- ☐ Transfer of Care from one agency to another ☐ Secondary/Emergency Contact
- ☐ Collection of Collateral Information ☐ Other:

Information to be Released

- ☐ Written/Electronic information *(diagnostic assessment and treatment plan)*
- ☐ Financial information and other data to document eligibility for funding
- ☐ Verbal information for coordination of your care and treatment
- ☐ Sensitive information including: drug, alcohol, psychological or psychiatric conditions and communicable diseases
- ☐ Laboratory Results
- ☐ Other: *(specify information to be released in the space below)*

Substance Use Division Only

- ☐ SUD Information Obtained from: _____
- ☐ Explicit description of Treatment Plan (SUD)
- ☐ Progress notes *(group/individual)*
- ☐ Discharge summary
- ☐ Continuing care plans
- ☐ SUD Assessment
- ☐ Other:

Service dates (*optional)*	Information needed by *(optional)*

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. *The provider/facility will not condition treatment on whether I sign the authorization.* **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐Legal Guardian or Conservator ☐Health Care Agent *(Health Care Power of Attorney)*
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐Parent ☐Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (Month, DD, YYYY)*

Printed Name of Person Signing *(If Not Patient)*			
Mailing Address of Patient – Street			
City	State	Zip Code	Phone