Authorization For Use and Disclosure of Protected Health Information

Client Information

First Name: ___________________ **Middle Name:** ________________ **Last Name:** __________________

Date of Birth: ______________

I authorize Northwestern Mental Health Center to do the following:

☐ Obtain From (One-way: NWMHC gets records) ____
☐ Release To (One-Way: NWMHC sends records) ____
☐ Exchange With (Two-Way: NWMHC gets and sends records) _________________________________

What are the approximate dates of information you want released? ____________________________

Purpose of Release:

☐ Coordination of Care
☐ Workers Compensation
☐ School
☐ Personal Use
☐ Insurance application
☐ Insurance payment/claim
☐ Litigation/Legal
☐ Other: ___________________________

What do you want released?

☐ Billing Records
☐ Chemical Dependency/ Substance Abuse Reports
☐ Comprehensive Assessment (SUD)
☐ Consultations
☐ Comprehensive Evaluation/ Diagnostic Assessment
☐ Discharge Summary
☐ Educational Information
☐ Crisis Documentation/ Emergency Reports
☐ History and Physical Exams
☐ Medical/Laboratory Records
☐ Medication List
☐ Progress/Provider Notes
☐ Psychiatric Reports
☐ Psychological Testing
☐ Treatment/Service Plan
☐ Other: _____________________________________

All information regarding alcohol and/or drug abuse or behavioral health will be released unless you restrict by initializing:

__________ Do not release alcohol and/or drug abuse information

__________ Do not release behavioral health information

Release Method/Format requested:

☐ Mail
☐ Fax
☐ Pick up (Photo ID is required at pickup time)

When is it needed? ____

NWMHC processes requests as they are received, but law allows us a maximum of 30 days to complete request.

- I understand that this authorization lasts for one year after the date of signature unless specified otherwise.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.293, WI Administrative Code HHS117, NDCC 23-12-14, Federal Rule 45 CFR 164.524; Charges may apply in ID. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.

☐ I wish for this authorization to expire prior to one year after the date of signature.
Date of Authorization Expiration: ______________________________

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

- If the client is 18 year of age or older, the client must sign and date the form.
- If the client is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
- If the client is 17 years of age or younger, the client's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. If this option is selected please indicate which legal exception:
  - ☐ I am married
  - ☐ I am the parent of a child
  - ☐ I am legally emancipated
  - ☐ Other: ________________________

Please indicate your relationship:

☐ Self
☐ Parent – Print Name: ___________________________
☐ Legal Guardian – Print Name: _________________________
☐ Conservator Health Care Agent/Health Care Power of Attorney – Print Name: ______________________

Authorized signature and date are required to release records. My signature indicates that I am legally authorized to sign.

Signature: ____

Date: __________