Northwestern Mental Health
Promoting Wellness, Instilling Hope

Release of Information

CLIENT INFORMATION
Date of Birth: _____

Legal Name:
First Name _____ Last Name _____

Preferred Name:
First Name _____ Last Name _____

This form may be used to authorize Northwestern Mental Health Center, Inc. (NWMHC) to obtain protected Health Information about you from other agencies or individuals. It may also be used to authorize NWMHC to send or provide your Health Information to other agencies or individuals.

I authorize Northwestern Mental Health Center to do the following:
☐ Disclose Information To
☐ Obtain Information From
☐ Disclose Information To and Obtain Information From (Exchange)

Request to disclose or obtain information from: _____

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

- 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 that Northwestern Mental Health Center may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- 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 release to expire prior to one year after the date of signature.
Date of Release 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: _____

My signature indicates that I am legally authorized to sign.

Signature: _____

Date: _____