NORTHERN PINES MENTAL HEALTH CENTER
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CLIENT INFORMATION:

NAME: _____ CLIENT NUMBER: _____
MAIDEN NAME: _____ PREVIOUS NAME: _____
DATE OF BIRTH: _____ PHONE: _____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP CODE: _____

I VOLUNTARILY AUTHORIZE: NORTHERN PINES MENTAL HEALTH CENTER

ADDRESS: _____ CITY: _____
STATE: MN _____ ZIP CODE: _____
PHONE NUMBER: _____ FAX NUMBER: _____

TO DO THE FOLLOWING: ☐OBTAIN FROM ☐RELEASE

TO AGENCY: _____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP CODE: _____
PHONE NUMBER: _____ FAX NUMBER: _____

PURPOSE OF RELEASE OF HEALTH INFORMATION:

☐COORDINATION OF CARE
☐CLIENT REQUEST
☐SOCIAL SECURITY DISABILITY/APPEAL
☐OTHER: _____
☐WORKERS COMPENSATION
☐INSURANCE CLAIM/PAYMENT
☐LEGAL/LITIGATION

WHAT DO YOU WANT RELEASED? ☐ANY & ALL RECORDS
☐RECORD DATE BETWEEN: _____ TO _____

☐DIAGNOSTIC ASSESSMENT/EVALUATION
☐PSYCHIATRIC REPORTS
☐PROGRESS NOTES
☐TREATMENT PLAN
☐MEDICAL/LAB RECORDS
☐VERBAL COMMUNICATION
☐PSYCHOLOGICAL TEST RESULTS
☐TREATMENT SUMMARY
☐DISCHARGE SUMMARY
☐MCO/CRISIS REPORT
☐ITEMIZED BILLING STATEMENT
☐OTHER:

SUBSTANCE USE DISORDER CLIENT

As a Substance Use Disorder client, I understand this release ☐is ☐is **not** to be given to a court service office related to a criminal sentence. This information is protected by Federal Regulations (42 CFR Part 2) which prohibits further disclosure of it without your specific written consent or as otherwise permitted as noted in our Privacy Notice. A general authorization for release of medical information is not sufficient for this purpose._____Initial

1. My health information is protected by Federal and Minnesota privacy laws. Disclosure is allowed only with my authorization, except in limited circumstances as described in our Privacy Notice. I understand I have a right to inspect and receive a copy of my treatment records that may be disclosed to others.
2. I can revoke this authorization at any time in writing, except A) to the extent that information has already been released per this authorization. B) To my insurance company as the law provides my insurer the right to contest a claim under my policy. Our Privacy Notice outlines the procedure for revocation. **This authorization will expire in one year from the date I sign, unless I request in writing an early expiration.**
3. My treatment may not be conditioned on my signing this authorization.
4. I understand that when my health information is sent to a third party, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal and state privacy laws.
5. Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR 164.524.
6. I have the right to have a copy of this form. A photocopy of this form will be treated in the same manner as the original.

CLIENT SIGNATURE: _____ **DATE:** Date

IF I AM SIGNING AS AN AUTHORIZED REPRESENTATIVE OF THE CLIENT, I AM: ☐PARENT ☐COURT APPOINTED GUARDIAN/CONSERVA

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** Date

WITNESS SIGNATURE: _____ **DATE:** Date