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**Northern Minnesota Addiction Wellness Center**

**4851 Stacy Ann Drive NW**

**Bemidji, MN 56601**

**AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 First Name Middle Initial Last Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Address City State Zip Phone Number

***I hereby authorize:***

Agency; Contact at agency *(individual name)* Address City State Zip

To: Obtain my information Release my information

Fax Number: Phone Number:

Information to be released is for **ALL Dates of Service** unless specified here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** Progress Notes **Yes No** Diagnostic Assessment **Yes No** Treatment Summary

**Yes No** Psychological Evaluation **Yes No** Educational Information **Yes No** Psychiatric Evaluation

**Yes No** Chemical Dependency **Yes No** Medical History & Treatment **Yes No** Court/Probation Info

**Yes No** Discharge Summary **Yes No** Medication List **Yes No** Lab Work

**Yes No** Other – Specify:

**The above information is released for the following purposes and those purposes only:**

 Treatment Planning Coordination of Services \_\_\_\_\_ Other:

 Please Describe

**I understand that:**

* The information will be used for the purpose specified and will not be disclosed to other sources unless specifically authorized by law.
* I may refuse to release this information and the consequences of this refusal have been explained to me.
* I may revoke this consent at any time, not retroactively, and that such revocation must be in writing.
* The information to be exchanged will be treated as private or confidential as governed by MN Government Data Practices Act, M.S. 13.01 to 13.88 and Federal regulations (42 CFR42 Part 2).
* This authorization will permit two-way telephone communication between the agencies or individuals listed above. This information may not be disclosed to anyone else other than those agencies or individuals listed above unless written permission is provided.
* I consent that a copy of this signed consent may be used in the same way and under the same restrictions as the original. I understand that when the health information specified is released to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy law.
* Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records.

**This consent will end one year from the date the form is signed unless I indicate an earlier date, event or condition here:**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Specific Event or Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient Signature Date**

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**Witness Signature Date**