

Authorization for Disclosure of Health Information

Please Print

Note: All items on this form must be completed to ensure prompt release of information.

If the form is incomplete, it will be returned and no information will be released until it is properly completed.

Client Information:	Client Name:		Date of Birth:	
	Previous Name(s):		Phone #:	
	Address:		E-mail Address (Optional):	
	City:	State:	Zip Code:	
Reason for Disclosure:	<input type="checkbox"/> Coordination of Care <input type="checkbox"/> Client Request/ Personal <input type="checkbox"/> Legal/ Court <input type="checkbox"/> Insurance Company <input type="checkbox"/> Financial/ Billing <input type="checkbox"/> Family Request <input type="checkbox"/> Other (Please Specify):			
How do you want the information released:	<input type="checkbox"/> Mail (Address required below) <input type="checkbox"/> Fax (For patient care only) <input type="checkbox"/> E-mail (E-mail address required below) <input type="checkbox"/> Pick-Up (Photo ID required @ pick-up) <input type="checkbox"/> Exchange With (Paper &/or Verbal) <input type="checkbox"/> Verbal Only (NO actual records given)			
Release Information From: Who has the information you would like to be released?	<input type="checkbox"/> CMMHC (We have centralized Health Information Management (HIM) for all programs/sites.)			
	Business Name:		Phone #:	
	Contact Name:		Fax #:	
	Address:	E-mail Address:		Zip Code:
Recipient: Where the information is going?	<input type="checkbox"/> CMMHC St Cloud <input type="checkbox"/> CMMHC Buffalo <input type="checkbox"/> CMMHC Elk River <input type="checkbox"/> CMMHC Midtown <input type="checkbox"/> CMMHC Monticello <input type="checkbox"/> CMMHC Detox <input type="checkbox"/> CMMHC Crisis <input type="checkbox"/> CMMHC IRTS <input type="checkbox"/> CMMHC Focus XII <input type="checkbox"/> CMMHC Bus. Off.			
	Business Name:		Phone #:	
	Contact Name:		Fax #:	
	Address:	E-mail Address:		Zip Code:
Information to be Released (Disclosed): If dates are not specified, only the most recent visit will be released.	Please Specify Dates of Service		From Date:	To Date:
	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Diagnostic Assessment (DA) <input type="checkbox"/> Psychological Evaluation <input type="checkbox"/> School Records <input type="checkbox"/> Verbal Only (No Records) <input type="checkbox"/> Medication Notes <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Legal/ Court/ PO <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Billing Records <input type="checkbox"/> Summary of Services <input type="checkbox"/> Social Services Info <input type="checkbox"/> Other (Please Specify):			
	Special Consents:			
	The law requires a Special Consent for Chemical Dependency Program Information. Please Specify Dates of Service From Date: To Date: <input type="checkbox"/> CD Assessment Summary <input type="checkbox"/> CD Weekly Summary Notes <input type="checkbox"/> CD Discharge Summary <input type="checkbox"/> Rule 25 <input type="checkbox"/> Verbal Only (NO records) <input type="checkbox"/> Other (Please Specify):			
Prohibition on Re-Disclosure: (42 CFR, Part 2)	Each disclosure made with the client's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.			
	Re-Disclosure: CMMHC cannot prevent the re-disclosure of records released as a result of this request, and after the information is released from CMMHC, the records may not be subject to the Federal Privacy Rule Laws. A photo copy of this authorization will be treated in the same manner as the original.			
Expiration: (Not to exceed 5 yrs.)	This consent will expire one year from the date the form is signed unless I indicate a different expiration date or event.			
	Date:	Specific Event: (can shorten or lengthen the expiration period)		
Revocation:	I have the right to revoke this authorization at any time by giving written notice to the Health Information Management (HIM) Department. I understand that the revocation will not apply: 1) to information that has already been released in response to this authorization, or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.			
Retrieval/ Copy Fee:	I may be required to pay a fee for retrieval and copying of records &/or inspection of records in accordance with 45 CFR 164.524.			
Authorization: <small>CMMHC may not condition my treatment, payment, enrollment, or eligibility for benefits by signing this auth.</small>	Client, or Parent, or Guardian Signature:		Date:	
	Reason the Client is unable to sign: <input type="checkbox"/> Minor <input type="checkbox"/> Legal (Documentation Required) <input type="checkbox"/> Client is not own Guardian (Documentation Required) <input type="checkbox"/> Other (Please Specify):			