cmmhc
Central Minnesota Mental Health Center

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:	☐ **Coordination of Care** ☐ **Client Request/ Personal** ☐ **Legal/ Court** ☐ **Insurance Company** ☐ **Financial/ Billing** ☐ **Family Request** ☐ **Other** (Please Specify):			
How do you want the information released:	☐ **Mail** (Address required below) ☐ **Fax** ☐ **E-mail** (E-mail address required below) ☐ **Pick-Up** (Photo ID required @ pick-up) ☐ **Exchange With** (Both parties) ☐ **Verbal Only** (NO actual records given)			
Release Information From: Who has the information you would like to be released?	☐ CMMHC (We have centralized Health Information Management (HIM) for all programs/sites.)			
	Business Name:		**Phone #:**	
	Contact Name:		**Fax #:**	
	Address:		**E-mail Address:**	
	City:	**State:**		**Zip Code:**
Recipient: Where the information is going?	☐CMMHC St Cloud ☐CMMHC Buffalo ☐CMMHC Elk River ☐CMMHC Midtown ☐CMMHC Monticello ☐CMMHC Detox ☐CMMHC Crisis ☐CMMHC IRTS ☐CMMHC Focus XII ☐CMMHC Bus. Off.			
	Business Name:		**Phone #:**	
	Contact Name:		**Fax #:**	
	Address:		**E-mail Address:**	
	City:	**State:**		**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:**	
	☐ **Progress Notes** ☐ **Medication Notes** ☐ **Treatment Plans** ☐ **Other** (Please Specify): ☐ **Diagnostic Assessment (DA)** ☐ **Billing Records** ☐ **Psychological Evaluation** ☐ **Psychiatric Evaluation** ☐ **Summary of Services** ☐ **School Records** ☐ **Legal/ Court/ PO** ☐ **Social Services Info** ☐ **Verbal Only** (No Records)			
Special Consents: If dates are not specified, only the most recent visit will be released. **Prohibition on Re-Disclosure:** (42 CFR, Part 2)	**The law requires a Special Consent for Chemical Dependency Program Information.**			
	Please Specify Dates of Service	**From Date:**	**To Date:**	
	☐ **CD Assessment Summary** ☐ **CD Weekly Summary Notes** ☐ **CD Discharge Summary** ☐ **Rule 25** ☐ **Verbal Only** (NO records) ☐ **Other** (Please Specify):			
	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: CMMHC may not condition my treatment, payment, enrollment, or eligibility for benefits by signing this auth.	**Client, or Parent, or Guardian Signature:**		**Date:**	
	Reason the Client is unable to sign: ☐ Minor ☐Legal (Documentation Required) ☐ Client is not own Guardian (Documentation Required) ☐Other (Please Specify):			

Return to: Central Minnesota Mental Health Center
Attn: HIM Dept. - 1321 13th St N St Cloud, MN 56303
Telephone #: 320.202.2028
Fax #: 320.202.2005
E-mail: HIMDept@cmmhc.com