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cmmhc
Central Minnesota Mental Health Center
Together, Creating a Healthier Life

Authorization for Disclosure of Health Information

FOR OFFICE USE ONLY: Staff Initials: _____
Route to HIM for Processing:
___ Add to the Contacts Tab ___ ROI on file
___ Request Records ___ Release Records

Client Information	Client Name: _____ Date of Birth: _____ Previous Name(s): _____ Address: _____ Phone #: _____ City: _____ State: _____ Zip Code: _____ E-mail Address (Optional): _____
I Authorize	**Central Minnesota Mental Health Center (CMMHC)** To do the following: ☐ Release To ☐ Receive From ☐ Both Release & Receive ☐ St. Cloud Campus ☐ Crisis ☐ Detox ☐ Focus XII ☐ Northway IRTS ☐ Buffalo Campus ☐ Elk River Campus ☐ Monticello Campus ☐ Waite Park Campus Contact Name/ Department: _____
With	Agency/ Name: _____ Phone #: _____ Address: _____ Fax #: _____ City: _____ State: _____ Zip Code: _____ E-mail Address (Optional): _____
What do you want released?	☐ Record Dates between: _____ to _____ ☐ Verbal ☐ Diagnostic Assessment/ DA Update ☐ Progress Notes ☐ Treatment Plans/ IFCSP ☐ Functional Assessment ☐ Psychiatric Evaluation ☐ Medication Notes ☐ Psychological Evaluation ☐ Summary of Services ☐ School Records ☐ Screening Tools ☐ Social Services ☐ Benefits/ Financial ☐ Legal/ Court/ PO ☐ Billing Records ☐ Other: _____
Purpose of Release	☐ Coordination of Care ☐ Client Request/ Personal ☐ Legal/ Court ☐ Insurance Company ☐ Financial/ Billing ☐ Family Request ☐ PCP Letter ☐ Other (Please Specify): _____
Substance Use Disorder (SUD) Special Consent	Per Federal Rule 42 CFR, part 2 this section must be completed to release SUD records. ☐ Dates of Service is REQUIRED between: _____ to _____ ☐ SUD Assessment Summary ☐ SUD Weekly Summary Notes ☐ SUD Discharge Summary ☐ Rule 25 ☐ Verbal ☐ Other: _____
Preferred Method	☐ Mail ☐ Fax ☐ E-mail ☐ Pick-Up
Authorization	This authorization will expire one year from the date of the signature below unless there is a different date/event indicated on the right. Client Signature: _____ Date: _____ I am signing as an authorized representative of the client, I am: ☐ Parent of a Minor ☐ Court Appointed Guardian/ Conservator Parent/ Guardian Signature: _____ Date: _____
	You can indicate a different date or event here to shorten or extend the release, not to exceed 5 years (144.293, Subd. 4) from the date of the authorized signature on the left: _____ _____

Disclaimer: CMMHC may not condition my treatment, payment, enrollment, or eligibility for benefits by signing this authorization. CMMHC cannot prevent the re-disclosure of records released because of this request, and after information is released from CMMHC, the records may not be subject to the Federal Privacy Rule Laws. SUD Records- 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 whom it pertains or as otherwise permitted by 42 CFR, part 2. A photo copy of this authorization will be treated in the same manner as the original. I have the right to revoke this authorization at any time by giving written notice to the 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.

Guidelines for Completing the CMMHC Authorization for Disclosure

Central Minnesota Mental Health Center (CMMHC) recognizes the importance of client confidentiality, as well as, the importance of coordinating care and treatment with other professionals, family, friends and others involved in your care. Please review all items on this form and contact CMMHC with any questions concerning this form at the offices listed below or on our website: https://cmmhc.org.

Client Information: Complete this entire section with clear and legible writing so the information identifies the client whose information is being requested/ released.

I Authorize: Please check by either: 1) Release To, 2) Receive From, or 3) Both Release & Receive. If you choose only "Release To" your CMMHC provider can only share information; If you choose only to "Receive From" your CMMHC provider CANNOT share any information; If you choose "Both Release & Receive" your CMMHC provider may share and receive information from the agency/ name listed on the form. CMMHC has centralized records. Please identify which CMMHC location correspondence should be sent to. If you specify a contact name/ department, that will help us ensure the information gets routed to the correct person.

With Agency/ Name: Indicate clearly and legibly where or whom you wish to send/ receive information with. Be as specific as possible.

What do you want Released? The purpose of this section is to have us share the information you want us to. Only the specific information checked will be released. If no dates are specified, we will only release the most recent DA and 3 progress notes. Minimum Necessary means we will use the least amount of information possible to accomplish the desired task. Select "Verbal" if you want us to release or obtain information verbally with the listed releasing/ obtaining party. Verbal is all inclusive. "Screening Tools" will include: SDQ/ CBCL, CASII/ ECSII, and Locus.

Purpose of the Release: Identify the reason you need to release/ request information. This helps CMMHC appropriately provide care and track releasing of confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. *Fees may be charged in accordance with MN statutes 144.292 and Federal Rule 45 CFR 164.524 (where applicable).

Substance Use Disorder (SUD) Special Consent: This section must be completed to allow CMMHC to release SUD records on your behalf. This information is 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 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. The dates of special consents are required to release SUD records. Select "Verbal" if you want us to release or obtain SUD information verbally with the listed releasing/ obtaining party. Verbal is all inclusive.

Preferred Method: This tells us how you would like your information provided. We can print and mail the documents, send them by fax, CONFIDENTIAL email, or we can print the records and make them available for you to pick-up at one of our locations.

Authorization and Revocation: Signing this form (or having the parent/ legal guardian sign for the client) will grant authorization to share/ receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the client or parent of a minor, you will be required to provide written proof of your authority (legal paperwork). This authorization will automatically expire in one year from the date signed unless a different date or event has been identified, not to exceed 5 years per (144.293, Subd. 4) from the date signed. This authorization can be revoked at any time by your written request to our HIM Department within our organization.

Helpful Tips:

- You may only enter one entity, clinic, or individual per Release of Authorization of Disclosure.
- If requesting records, please allow 7-10 business days for processing of the Release of Information (ROI). In some cases, it can take up to 30 days (45 CFR 164.524(b)(2)(i).
- For questions or concerns reading this form, please contact the Health Information Management (HIM) Department: by phone at: 320.202.2028, by fax at: 320.202.2005, or by email at: HIMDept@cmmhc.com.

Locations:

▪ St. Cloud Campus-	1321 13th St. N, St Cloud, MN 56303	320.252.5010	Fax: 320.252.0908
▪ Buffalo Campus-	308 12th Ave S, Buffalo, MN 55313	763.682.4400	Fax: 763.682.1353
▪ Elk River Campus-	253 8th St. NW, Elk River, MN 55330	763.441.3770	Fax: 763.441.9057
▪ Monticello Campus-	407 Washington St., Monticello, MN 55362	763.295.4001	Fax: 763.295.5086
▪ Northway IRTS-	1509 24th Ave. N, St. Cloud, MN 56303	320.252.8648	Fax: 320.529.4909
▪ Focus XII-	3220 Veterans Drive, St. Cloud, MN 56303	320.252.2425	Fax: 320.529.1976
▪ Waite Park Campus-	411 3rd St. N, Waite Park, MN 56387	320.230.0611	