



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

Authorization for Disclosure of Health Information

Client Information	Client Name: _____ Date of Birth: _____ Previous Name(s): _____ Address: _____ Phone #: _____ City: _____ State: _____ Zip Code: _____ Email Address (Optional): _____	
I Authorize	Central Minnesota Mental Health Center (CMMHC) To Do the Following: ☐ Release Information To ☐ Receive Information From ☐ Both, Release & Receive	With Business/ Contact Person: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone #: _____ Fax #: _____ Email Address: _____
Information to Be Released	☐ Any & All Records (Past, present and future dates) ☐ Or Specific Dates of Service from: _____ to: _____ and records, please select below: ☐ Verbal/Collateral ☐ Assessments/ Evaluations ☐ Progress Notes ☐ Treatment Plan ☐ Substance Use Disorder Records ☐ School Records ☐ Benefits/ Financial ☐ Social Services ☐ Billing Records ☐ Summary of Services ☐ Other (Please Specify): _____ _____ Please Note: CMMHC is part 2 provider, therefore, medical records may contain sensitive information including SUD.	
Purpose of Release	☐ Coordination of Care ☐ Client Request/ Personal* ☐ Family Request/ Involvement ☐ PCP Letter ☐ Court/ Legal* ☐ Insurance Payment/ Claim* ☐ Social Security Disability/Appeal* ☐ Other (Please Specify): _____ *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR 164.542.	
Method of Communication	☐ Secure Email ☐ Postal Mail ☐ Fax ☐ Pick-up in-person ☐ Verbal/Collateral	
Authorization	This authorization will expire one year from the date of the signature below unless there is a different date/ event indicated. 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 above: _____ _____	

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 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, HIPAA, and 45 CFR Parts 160,164. SUD records may not be re-disclosed to investigate or prosecute a client. A photocopy of this authorization will be treated in the same manner as the original. I have the right to revoke this authorization at any time 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. **With Business/ Contact Name:** Indicate clearly and legibly where or whom you wish to send/ receive information with. Be as specific as possible.

Information to be 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 you choose Any and All Records, CMMHC will be able to send any information within your records including all programs. Select “Verbal/Collateral” if you want us to release or obtain information verbally with the listed releasing/ obtaining party. Verbal is all inclusive.

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).

Method of Communication: This tells us how you would like your information provided. We can print and mail the documents, send them by fax, Secure (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: 320.703.4352, by fax at: 320.202.2005, or by email at: HIMDept@cmmhc.org.

Location	Address	City, State, Zip	Telephone #	Fax #
St Cloud Campus	1321 13 th St N	St Cloud, MN 56303	320.252.5010	320.252.0908
Crisis	1350 14 th St N	St Cloud, MN 56303	320.253.5555	320.774.3080
Buffalo Campus	308 12 th Ave S	Buffalo, MN 55303	763.682.4400	763.682.1353
Elk River Campus	253 8 th St NW	Elk River, MN 55330	763.441.3770	763.441.9057
Monticello Campus	407 Washington St	Monticello, MN 55362	763.888.9626	763.295.5086
Waite Park Campus	411 3 rd St N	Waite Park, MN 56387	320.230.0611	320.251.4175