Northern Pines Mental Health Center
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information	Name: ______ Date of Birth: ______ Client #: ______ Maiden Name: ______ Previous Name: ______ Address: ______ Phone: ______ City: ______ State: ______ Zip: ______
I Authorize	Northern Pines Mental Health Center: (Location) ______ Fax: ______ Phone: ______
To **do** the following ☐ Obtain from ☐ Release to ☐ Exchange with	Agency/Name: ______ Fax: ______ Address: ______ Phone: ______ City: ______ State: ______ Zip: ______
Purpose of Release (Why is it needed?) Check the appropriate box(s)	☐ Coordination of care ☐ Worker Compensation ☐ Personal Use ☐ Social Security Appeal ☐ Insurance Payment/Claims ☐ Other: ______ ☐ Social Security Disability ☐ Litigation/Legal
What do you want released?	☐ Record Dates Between ______ to ______ ☐ Any and All records ☐ Verbal ☐ All Types of Written Communication
	☐ Diagnostic Assessment ☐ Comprehensive Assessment Summary ☐ Psychological Testing Interpretive Report ☐ Comprehensive Assessment ☐ Psychiatric Reports ☐ Treatment Summary ☐ Progress Note ☐ Discharge Summary ☐ Treatment/Service Plan ☐ Medical/Laboratory Records ☐ Educational information ☐ MCO/Crisis Report ☐ Other: ______ ☐ Itemized Billing Statement
Alcohol and/or Drug abuse release	**No** information regarding Alcohol and/or Drug Abuse treatment will be released **unless you** authorize by initialing: _____ Release Alcohol and/or Drug information. As a SUDS Client I understand this release ☐is ☐ is **not** given to a court services office relating to a criminal sentence. I understand I cannot withdraw this consent for 60 days or until my legal status changes if I am here because of a court order related to a crime. This information is protected by federal law. Federal regulations (42 CFR part 2) prohibit further disclosure of it without your specific written consent or as otherwise permitted by such regulations. A general authorization for releases of medical or other information is NOT sufficient for this purpose.

1. My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Northern Pines Mental Health's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
2. I can revoke this authorization at any time in writing except to the extent that action has been released according to this authorization. Northern Pines Mental Health's Privacy Notice outlines the procedure for revocation. **This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.**
3. For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR §164.508 (b)(4)(III)
4. Communications resulting from this authorization will reveal that I receive services at Northern Pines Mental Health.
5. Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Northern Pines Mental Health to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
6. This authorization may be used by Northern Pines Mental Health owned or managed programs upon transfer of my care to them.
7. Fees may be charged in accordance with MN Statue 144.292 and Federal Rule 45 CFR §164.524

Client Signature ______________________ Date ______________
Client need to sign if sixteen (16) or older

If I am signing as authorized representative of the client, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator

Parent/Guardian Signature: ______________________ Date ______________

Witness Signature: ______________________ Date ______________

Guidelines for completing your Authorization for Releasing of Information

Northern Pines Mental Health Center, Inc. (NPMHC) recognizes the importance of patient 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 NPMHC with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information identifies the patient whose information in being requested/released.

Agency/Name: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific as** you can. **Also,** please check by either: (1) Obtain from, (2) Release to, (3) Exchange with. If you choose only to obtain information your NPMHC provider **CANNOT** share any information; if you choose Release to your NPMHC provider can only share information; if you choose both to Obtain **AND** Receive they may share and receive information from the agency/name listed on the form.

Purpose of Release: Identify the reason you need to release/request information. This helps NPMHC 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 statute 144.292 and Federal Rule 45 C.F.R. §164.524 (when applicable)*

What do you want us to Obtain/Release: The purpose of this section is to have us share the information you want us to. "**Any and all medical records**" NPMHC will release/obtain **Any and ALL** medical records across **ALL programs/services** at NPMHC. Select **Record dates** between __ to__, NPMHC will only send the records in the date range you indicate. Select **Verbal** if you want to release or obtain information verbally with the listed releasing/obtaining party. Select **All Types of Written Communication** if you want to release or obtain all types of written communication with the listed releasing/obtaining party.

Authorization and Revocation: Signing this form (or having the 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 patient the patient, you will be required to provide written proof of your authority; This consent will automatically **expire in one year from the date signed.** The authorization **can be revoked or can be edited** at any time at your written request to our Privacy Officer within our organization.

Helpful Tips:

- You may only enter one entity, clinic, or individual per Release of Information form.
- IF requesting records, please allow **7-10 business days** for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).

For questions or concerns regarding this form, please contact Health Information Department/Medical Records/ Privacy Officer at 218-454-3824 or by fax at 218-249-1506 or one of the locations listed below:

Office	Address	City	Phone	Fax
AITKIN OFFICE	#13 3rd Street NE	Aitkin, MN 56431	(218) 928-8003	FAX: (218) 928-8006
BRAINERD OFFICE	520 5th Street NW	Brainerd, MN 56401	(218) 829-3235	FAX: (218) 829-1368
LITTLE FALLS OFFICE	P.O. Box 367	Little Falls, MN 56345	(320) 632-6647	FAX: (320) 632-9525
LONG PRAIRIE OFFICE	16 Ninth Street SE	Long Prairie, MN 56347	(320) 732-6602	FAX: (320) 732-6581
MAPLE STREET OFFICE	823 Maple Street	Brainerd, MN 56401	(218) 454-3826	FAX: (218) 454-1024
PINE RIVER OFFICE	245 Barclay Avenue	Pine River, MN 56474	(218) 587-3271	FAX: (218) 587-3272
STAPLES OFFICE	200 4th Street NE	Staples, MN 56479	(218) 894-1002	FAX: (218) 894-0131
WADENA OFFICE	11 2nd Street SW, Suite 1	Wadena, MN 56482	(218) 631-1714	FAX: (218) 631-4228
ACT OFFICE	606 Front Street	Brainerd, MN 56401	(218) 316-3800	FAX: (218) 316-3819
ARMHS OFFICE	212 2nd Street SE	Little Falls, MN 56345	(320) 639-2021	FAX: (320) 639-0014
MCO OFFICE	823 Maple Street	Brainerd, MN 56401	(218) 454-7205	FAX: (218) 454-3831
OUR PLACE PEER CENTER	323 So.9th Street	Brainerd, MN 56401	(218) 828-4877	FAX: (218) 825-0320
SAFE HARBOR	201 W. Laurel Street	Brainerd, MN 56401	(218) 454-3844	FAX: (218) 454-3848