2031 Rowland Rd., Mora, MN 55051
(P) 844-314-HOPE (F) 651-323-2558
www.recoveirnghope.life

Authorization To Release Protected Health Information

Legal Name: ____________________ DOB: __________ SSN: ___________ Phone #: _______________

Address: _________________________ City: _________ State: ______ Zip Code: _______________

1. **I hereby authorize Recovering Hope Treatment Center, Address: 2031 Rowland Rd, Mora, MN 55051**

2. **To: ☐ Obtain Information ☐ Release Information ☐ Exchange information**

To/From:

Name/Organization:

Address:

Phone:

Fax:

Email:

3. **The following information:**

Substance Use Records	**Mental Health Records**	**Medical Records**	**Other**
☐ Comprehensive Assessment	☐ Diagnostic Assessment	☐ Medication List	☐ Emergency Contact
☐ Individual Treatment Plan	☐ Individual Treatment Plan	☐ Medical History	☐ All Children Information
☐ Weekly Progress Note	☐ Discharge Summary	☐ UA & Labs	☐ Acknowledgement of client's access to services
☐ Discharge Summary	☐ Psychological Testing	☐ Progress Note	☐ Permission to pick up client belongings
☐ Other ____________	☐ Other ____________	☐ Other ________	☐ Other ________________________
			☐ Other ________________________

4. **Purpose for disclosure:**
☐ Referral ☐ Case Management ☐ Care Coordination ☐ Consultation ☐ Collateral Contact ☐ Other:________

5. **Client Restrictions on Methods for Disclosure.** I understand that communication of the items can occur:
☐ Verbally ☐ In person conference ☐ Written questionnaire ☐ Mailed or faxed medical record / correspondence

6. **I authorize the release of protected information for all dates of services**.
Only if I would to limit the timeframe, disclosed I will indicate the timeframe here: ____________ to ____________

7. **I understand that:**

- 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 Recovering Hope Treatment Center'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.
- 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)
- Communications resulting from this authorization will reveal that I receive services at Recovering Hope Treatment Center.
- Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Recovering Hope Treatment Center 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.
- This authorization may be used by Recovering Hope Treatment Center owned or managed programs upon transfer of my care to them.
- This information is confidential and will only be used for business purposes and then shredded after 7 years as regulated by HIPAA/confidentiality laws below: Information to be 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.

______________________________ ____________________
Client Signature (required) Date:

______________________________ ____________________ ____________________
Signature of Witness/Staff Printed Name: Date: