Recovering HOPE
Transforming Families
Restoring Hope

2031 Rowland Rd, Mora, MN 55051
Phone: (844) 314- 4673
www.recoveringhope.life

Authorization To Release Protected Health Information

Legal Name: _____ **Date of Birth (DOB):** _____ **SSN:** _____

Phone Number: _____ **Email:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

1. I hereby authorize **Recovering Hope Treatment Center at 2031 Rowland Rd, Mora, MN 55051**
2. **To:** ☐ Obtain Information ☐ Release Information ☐ Exchange information
3. **To/from: Name/Organization:** _____ **Address:** _____

   Phone: _____ **Email:** _____
4. **The following information:**

Substance Use Records	Medical Records	Mental Health Records	Other
☐ SUD Comprehensive Assessment	☐ Medication List	☐ Diagnostic Assessment	☐ Acknowledgment of Services
☐ SUD Individual Treatment Plan	☐ Comprehensive Medical Assessment	☐ MH Individual Treatment Plan	☐ Financial, Insurance and Funding Info
☐ SUD Weekly Treatment Plan	☐ UA & Labs	☐ MH Discharge Summary	☐ Emergency Contact Information
☐ SUD Discharge Summary	☐ Medical Progress Note	☐ Psychological Testing	☐ Permission to pick up client belongings
☐ Other _____	☐ Other _____	☐ Other _____	☐ Child Information
			☐ Other _____

5. **Purpose for disclosure:**
   ☐ Referral ☐ Case Management ☐ Care Coordination ☐ Consultation ☐ Collateral Contact ☐ At the Request of the Client
   ☐ Other _____
6. **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
7. **I authorize the release of protected information for all dates of services**.
   *If I would to limit the timeframe disclosed, I will indicate it here:*_____
8. **I understand that:**
   - My health information is protected by federal regulations — including 42 CFR Part 2 (Alcohol and Drug Abuse Patient Records) and 45 CFR (HIPAA) — as well as applicable state privacy laws. Disclosure is permitted only with my written authorization, except in limited circumstances described in Recovering Hope Treatment Center's Privacy Notice. I have the right to inspect and receive a copy of my treatment records in accordance with applicable laws.
   - I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. The procedure for revocation is outlined in Recovering Hope Treatment Center's Privacy Notice. Unless otherwise specified in writing, this authorization will expire one year from the date it is signed, or earlier if requested in writing.
   - For disclosures other than those made for treatment, payment, or healthcare operations, Recovering Hope Treatment Center may not condition my treatment on signing this authorization — unless I am receiving services solely for the purpose of creating information to be disclosed to a third party. (45 CFR § 164.508(b)(4)(iii))
   - Communications resulting from this authorization may reveal that I receive services at Recovering Hope Treatment Center. Federal confidentiality rules (42 CFR Part 2) prohibit the re-disclosure of any substance use disorder (SUD) information. However, I understand that HIPAA requires Recovering Hope to inform me that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA.
   - This authorization may also be used by other Recovering Hope-owned or managed programs if I transfer care to those programs.
   - All disclosed information will be treated as confidential and will only be used for business and treatment coordination purposes. Records will be retained as required and securely destroyed after seven (7) years, in compliance with HIPAA and 42 CFR Part 2.
   - Notice to recipient: Information disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) must not be further disclosed unless expressly permitted by the written consent of the individual to whom it pertains or as otherwise allowed by law. A general authorization is not sufficient for this purpose. These rules also prohibit the use of disclosed information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____

Client Signature (required) Date:

_____ _____ _____

Signature of Staff/Witness (if applicable) Printed Name: Date: