



1420 N. State Street
Fairmont, MN 56031
Phone: (507) 235-6070
Fax: (855) 847-9876

Authorization for Release of Information

I, _____

Name of Client	Date of Birth
Address	Social Security Number - Optional
City, State, Zip	Phone Number

authorize Eunoia Family Resource Center, 1420 N. State Street, Fairmont, MN 56031, to disclose to and receive information from:

Name of Individual and Organization Name, if Applicable

Street Address	City, State, Zip
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Phone Number	Fax Number	
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The following information that relates to my treatment: _____ Any of the Following Information

_____ Summaries (Case, Discharge, etc.)	_____ Treatment Plans and Reviews	_____ Emergency Contact
_____ Chemical Health Information	_____ Scheduling	_____ Medical History and Physical
_____ Diagnostic Assessment	_____ Questionnaires/Screeners	_____ Neuro-/Psychological Testing
_____ Legal	_____ Notes (Case, Progress, Group, etc.)	_____ UA/Labs
_____ Medications/Dosage	_____ Consults	_____ Billing

Purpose for Disclosure: _____ Coordination and/or Continuation of Care _____ Other: _____

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items can occur: _____ Any of the Following Information

_____ Verbally	_____ In-person Conference	_____ Written
_____ Mailed or Faxed Medical Record/Correspondence	_____ E-Mailed Records/Correspondence	

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 Eunoia Family Resource Center, PA'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.
- *I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Eunoia Family Resource Center, PA'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.
- This Authorization for Release of Information will remain in effect until: _____.
- *For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorize (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 Eunoia Family Resource Center, PA.
- *Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Eunoia Family Resource Center, PA, 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 Eunoia Family Resource Center, PA, owned or managed programs upon transfer of my care to them.

_____	_____
Patient or Guardian Signature	Date