1400 Madison Avenue, Suite 602
Mankato, MN 56001
Phone: (507) 779-7366
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, 1400 Madison Ave Suite #602 Mankato, MN 56001, to disclose to and receive information from:

____
Name of Individual and Organization Name, if Applicable

____
Street Address City, State, Zip

________________________ _______________________
Phone Number Fax Number

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