



1226 S. Broadway
New Ulm, MN 56073
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, 1226 South Broadway New Ulm, MN 56073, 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