AUTHORIZATION TO RELEASE & DISCLOSE CLIENT INFORMATION

CLIENT INFORMATION	Name_____ Date of Birth ___/___/_____ Address_____ Phone_____ _____ City, State, Zip
DISCLOSING PARTY	Mn Prevention & Recovery Alliance 740 E 24th St, Minneapolis MN 55404 ATTN:_____ Email_____ Phone_____
RECEIVING PARTY	☐ Medical, Chemical, or Mental Health Facility Provider Organization Name_____ ATTN: Records Department Address_____ Phone _____ _____ City, State, Zip ☐ Other Facility/Name _____ ATTN:_____ Address_____ Phone_____ _____ City, State, Zip
INFORMATION TO BE RELEASED	☐Any and All Records (including those specified below) ☐I authorize the Disclosing Party and Receiving Party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if applicable) ☐Chemical dependency/substance use records ☐Legal ☐ Mental health or medical records ☐ Financial records ☐ Other (Specify): _____
RELEASE INSTRUCTIONS	Date the information is needed (please allow 7-10 days for processing): Release Method format requested: ☐Paper ☐Fax ☐Email ☐Verbal ☐Other:

PURPOSE OF RELEASE	☐ Treatment/Continued Care ☐ Personal* ☐ Progress Notes ☐ Transfer of Care ☐ Financial/Insurance ☐ Legal* ☐ Other: *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. 164.524

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here _____ unless earlier revoked; (ii) my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; (iii) I can revoke this Authorization, in writing at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; (iv) I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnPRA address listed above; (v) once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; (vi) I can refuse to sign this Authorization and still be assured treatment; (vii) I may inspect or copy the information to be used or disclosed, as provided in the 45 CFR 164.524; (viii) a photocopy/fax of this Authorization will be treated in the same manner as the original; and (ix) MnPRA records may include records that it received from other organizations. If these records have been used by MnPRA and filed in the record MnPRA maintains about me, these records may be released with my MnPRA records.

By signing below I acknowledge that I have read and understand this form, and authorize release of the information described above.

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CLIENT SIGNATURE DATE