MNPRA AUTHORIZATION TO RELEASE & DISCLOSE PARTICIPANT INFORMATION

All information is required for a valid ROI and must be completed in its entirety*

Participant Information

First Name_____ Last Name_____ DOB____/____/____.Phone(____)____-
Email_____. SSN____-____-____.
Address_____ .City_____. State ____.
Zip_____.County_____.

Receiving Party – MN Prevention & Recovery Alliance

Address: 740 E 24th Street, Minneapolis, MN 55404 Email: Prss@mnpra.org Phone: (612) 238-6393 Fax: (651) 204-9383

☐ *I authorize the receiving and disclosing parties listed on this release to continuously exchange information in regard to the service I am receiving related to my substance use disorder. My authorization is valid until the expiration of this release or until I revoke my permissions.*

Disclosing Party – Treatment Provider **Where chemical health, diagnostic or comprehensive assessment was completed so that MnPRA can obtain a copy.*

Provider Name_____.

Provider Address_____ City_____ State_____ Zip_____.

Phone (____)____-_____ Email_____ Fax (____)____-_____.

Information to be Released **If you check the "All Records," box please do not check any additional boxes - "All Records," includes those specifically listed. If you only want to disclose specific records, please select those records and do not check "All Records."*

☐ ***All records, including those specified below.***
Only Records Specifically Checked Below:

☐ Discharge Summary
☐ Progress/Clinic Notes
☐ Mental/Chemical Health Records
☑ Chemical/Diagnostic/ Rule 25/Comprehensive Assessment
☐ Financial Records/Insurance Information

Optional Limits: *Disclose information only related to the following:*

☐ Date(s) of service:_____.

Release Method Format

☑ All Method ☐ Paper ☐ Fax ☐ Verbal ☐ Email ☐ Other:_____.

Purpose of Release ***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule CFR 164.524*

☑ Treatment/Care Coordination ☐ Personal* ☐ Transfer of Care ☐ Progress Notes ☐ Financial/Insurance
☐ Legal* ☐ Other _____.

I agree that: (i) this Authorization is effective for one year from the date I sign below 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 refused to sign this Authorization and still be assured services; (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

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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. (x) By initialing I understand that I specifically authorize the disclosure/exchange of information related to my chemical dependency and/or substance abuse. _____ *(Initials of Consenting Party)*

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

Participant signature _____ Date _____/_____/_____.