501 N. Columbia Road Stop 7132
Columbia Hall Room 1300 Grand Forks, ND 58202
Phone: 701.777.3745 Fax: 701.777.3845

AUTHORIZATION FOR RELEASE/EXCHANGE OF PROTECTED HEALTH INFORMATION

This completed and signed form authorizes release of protected health information to the person or institution designated.

Client Name (First, MI, Last): ______________________ Date of Birth: ______________

Address: ______________________ Phone: ______________

____

I authorize, Northern Prairie Community Clinic, to exchange via verbal, written, facsimile and directly exchange electronically:

☐ to release to: ☐ to receive from: ☐ to mutually exchange with:

Name/Facility: ______________________

Address: ______________________

____

Phone: ______________________ Fax: ______________________

INFORMATION TO BE RELEASED:

Dates of service requested (1 year history unless specified): ______________________

☐ Verbal Communication	☐ Written Communication	☐ Psychological /Neuropsychological Evaluation
☐ Intake Assessment	☐ Progress Notes	☐ Treatment Plan/Summary
☐ Collateral Information	☐ Recommendations	☐ Discharge/Termination Summary
☐ Billing	☐ Scheduling	☐ Acknowledgement of client's access of service
☐ Other: ______________		☐ Other: ______________

PURPOSE(S):

The purpose of this release is to facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed Northern Prairie Community Clinic for evaluation or treatment services.

This authorization shall be in effect for 2 years from the date of signature unless otherwise specified: ______________

I understand that:
This authorization remains in effect until the above date or event unless revoked by written notice at anytime, except to the extent action has already been taken in reliance on it. Refer to the Privacy Notice for instructions regarding how to revoke authorizations.

The authorization for release of information is voluntary. My health information is protected by federal regulations (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 Northern Prairie Community Clinic's Privacy Notice and Informed Consent. I understand that I have the 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. For disclosure other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to at third party (42 CFR 164.508(b)(4)(iii)). Federal confidentiality regulations (43 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Northern Prairie Community Clinic to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by HIPAA rules.

Client Signature (or parent/legal guardian/representative):	Relationship to Client (if not self):	Date:

Witness Signature:	Date:

Revised 9/21/22