Northern Prairie Community Clinic
501 N Columbia Rd Stop 7132
Grand Forks ND 58202-7132

Phone: 701.777.3745
Fax: 701.777.3845

Authorization for Use and Disclosure of Confidential Information

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

Name (First, MI, Last): ______________________________ Date of Birth: ____________________

Address: ______________________________ Phone: (____)______ - __________

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I authorize Northern Prairie Community Clinic to: ☐ **to release to:** ☐ **to receive from:** ☐ **mutually exchange with:**

Name/Facility: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ____________________ **Fax:** ____________________

INFORMATION TO BE RELEASED:

- ☐ Access for All Scholarship Funding
- ☐ Acknowledgement of client's access of service
- ☐ Alcohol and Drug Evaluation
- ☐ Assessment/Admission/Intake/Evaluation
- ☐ Billing
- ☐ Other: ______________________________
- ☐ Collateral Information
- ☐ Conditions of Parole/Probation
- ☐ Discharge/Termination Summary
- ☐ Lab Results: Urine Drug Screen
- ☐ Progress in Treatment
- ☐ Recommendations
- ☐ RHS Student Access of services
- ☐ Statements
- ☐ TeleCounseling
- ☐ Treatment Summary

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.

Information can be communicated: ☐ **Verbally** ☐ **Written** ☐ **Facsimile (same as original)** ☐ **Other:** ____________________

I understand that:

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 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 in writing at any time, except to the extent action has already been taken in reliance on it. Northern Prairie's Privacy Notice outlines the procedure for revocation. This authorization shall be valid for 2 years from the date of signing.

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 a 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.

Print client name (or parent/legal guardian/representative)	**Date**
Client signature (or parent/legal guardian/representative)	**Date**
Witness Signature	**Date**