

Release of Information

☐ Please fax to 715-318-5644

☐ For urgent requests requiring a response within a week, please fax to 715-318-5635

1. Personal Information Patient Legal Name _____ Date of Birth _____ Please include <u>date of birth</u> Patient Maiden/Previous Name _____ Phone number _____		2. Release Purpose ☐ Continued Care ☐ Disability ☐ Legal ☐ School ☐ Transfer Care Please mark all that apply ☐ Work Comp ☐ Self/Personal ☐ Other (Please Specify) _____	
3. Release FROM Who has the information you want released? Name/Organization: _____ Phone: _____ Fax: _____ Street Address: _____ City: _____ State: _____ ZIP: _____			
4. Release TO Where do you want the records sent to? Complete address is required Name/Organization: _____ Phone: _____ Fax: _____ Street Address: _____ City: _____ State: _____ ZIP: _____ Email address: _____ <i>(NorthLakes will use encrypted email for security purposes)</i>			
5. Release Type ☐ Release Records ☐ Verbal Communication			
6a. Information to be released: For continued care the last 2 years of records will be sent unless a different time frame is specified. ☐ Progress Notes ☐ Lab Reports/Pathology ☐ Medication List ☐ Radiology Reports ☐ Radiology Images ☐ HIV/AIDS ☐ Sexually Transmitted Disease (STD) ☐ Entire Medical File ☐ Entire Dental File (including images) ☐ OT/PT/ST Evaluation and Plan of Care ☐ Other: _____		6b. Information to be released: Mental Health, Substance Use Disorder, Psychiatric Medication Management <u>Dates Required</u> Mental Health/Substance Use Treatment/Psychiatry Records REQUIRED DATE RANGE Start Date: _____ End Date: _____ ☐ YES, please include records created after date of signature Mental Health: ☐ Progress Notes ☐ Assessment/Evaluation ☐ Discharge Summary ☐ Entire File Substance Use Treatment: ☐ Progress Notes ☐ Assessment/Evaluation ☐ Discharge Summary ☐ Entire File Psychiatry: ☐ Progress Notes ☐ Assessment/Evaluation ☐ Discharge Summary ☐ Entire File Other: _____	

By signing this authorization I understand that:

- The disclosure of this health information is voluntary and I may decline to sign this authorization.
- This authorization will expire one year from my signature date unless I revoke it.
- NorthLakes Community Clinic will not condition treatment on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- Information in my medical records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychiatric management, behavioral and mental health services, and treatment for substance abuse.
- Records created as part of Substance Abuse treatment cannot be disclosed without my written consent Per 42 CFR Part 2 and/or HIPAA 45 CFR
- I have a right to request a copy of the signed authorization and to inspect and receive a copy of the information disclosed.
- This authorization may be revoked at any time by providing written notice of revocation to NorthLakes Community Clinic, except when information has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Date	Patient Signature
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Date _____ Parent/Guardian Signature _____

For Substance Use Treatment patients 12 and older, both patient and parent/legal guardian must sign.

For Mental Health and Psychiatry patients 14 and older, both patient and parent/legal guardian must sign