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Counseling Services of Southern Minnesota

# Release of Information

**Client Name:** _____ **DOB**: _____ **Date:** _____

**I,** _____ **, authorize Counseling Services of Southern MN, Inc to:**

| **Exchange Information With:** | **Name:** | **Number:** |
|---|---|---|
| ☑ Other: Staff and Personnel at | | |

**The following information to be Exchange:**

- ☑ Discharge Summary
- ☑ History and Physical
- ☑ Consults
- ☑ Neuropsychological/Psychological testing
- ☑ Diagnosis
- ☑ Chemical Health Information
- ☑ Case Plan/Notes
- ☑ Medications/Dosage
- ☑ Other: The following educational records (if applicable) including, but not limited to, assessments/evaluations, IEP and 504 plans, grades/transcripts, special education records, teacher notes, speech therapy and occupational therapy records

**Purpose for disclosure:** Coordination of Care

**ROI Valid Dates:** _____ - _____

**Records Request Dates:** _____ - _____

**Patient Restrictions on Methods for Disclosure:**

I understand that communication of the items to Exchange can occur:

☑ Verbally ☑ In person conference ☑ Written questionnaire ☑ Mailed or faxed medical record / correspondence

I understand that:

* My health information is protected by federal regulation (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 Counseling Services of Southern MN, Inc's Privacy Notice. 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 at any time except to the extent that action has been taken in reliance on it. Counseling Services of Southern MN, Inc's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)
* Communications resulting from this authorization will reveal that I receive services at Counseling Services of Southern MN, Inc.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Counseling Services of Southern MN, Inc to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
* This authorization may be used by Counseling Services of Southern MN, Inc owned or managed programs upon transfer of my care to them.

Counseling Services of Southern Minnesota

**Patient Signature** _____ **Date:** _____

**Parent/Guardian Signature** _____ **Date:** _____

**Witness Signature** _____ **Date:** _____

**Staff Signature** _____ **Date:** _____

**** Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**