Authorization For Release/Disclosure of Confidential Records and Information

I, _____, whose date of birth is _____,
(Patient's Legal name)
hereby authorize Open Range Counseling Center to obtain or disclose the following information to:

_____
(Person or facility)

_____
(address)

_____
(Phone and/or fax)

Description of Information to be disclosed (check all that apply):

_____ Evaluation/Intake/Assessment
_____ Medication Management Information
_____ Progress Notes/Clinic Notes
_____ Lab Results
_____ All Records
_____ Treatment Plan or Summary
_____ Discharge/Transfer Summary
_____ Verbal and Written Communication
_____ Appointment History
_____ Other:

All Dates of service unless otherwise specified here: _____

For the following purpose(s):

_____ Mental health treatment /evaluation
_____Coordination of care
_____Medical
_____Billing
_____Legal
_____Client request
Other, please specify: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/ OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

____ Do **NOT** release alcohol or drug treatment records protected under federal law

This information has been 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. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information. 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.

I have had it explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

I will be given a copy of this authorization for my records, upon my request.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date

_____
Signature of Staff Witness Date