Authorization for Release of Information

I, _____ **Authorize** VEEMAH Integrated Wellness and Consulting Services, LLC

Address: 7070 Brooklyn Blvd, Brooklyn Center, MN 55429 Fax #: 763-355-5718 Phone #: 763-202-4767

to exchange information with: *Name, Address, Phone, Fax, Email*

_____

_____

_____

The following information:

- ☐ Assessments/Summaries
- ☐ Chemical Health Information
- ☐ Diagnosis
- ☐ Emergency Contact
- ☐ Medical History and Physical
- ☐ Neuropsychological / Psychological Testing
- ☐ Treatment Plans and Reviews
- ☐ Case Plan/Notes
- ☐ Consults
- ☐ Discharge Summary
- ☐ Legal
- ☐ Medications/Dosage
- ☐ Progress/Group Notes
- ☐ UA/Labs

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items 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 VEEMAH Integrated Wellness and Consulting Services, LLC'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. VEEMAH Integrated Wellness and Consulting Services, LLC'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.

This Authorization for Release of Information will remain in effect until: _____

* 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 VEEMAH Integrated Wellness and Consulting Services, LLC.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires VEEMAH Integrated Wellness and Consulting Services, LLC 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 VEEMAH Integrated Wellness and Consulting Services, LLC owned or managed programs upon transfer of my care to them.

Patient Name (Print)_____ **Date:**_____

Patient or Guardian Signature:_____ **Date:**_____

Staff Name (Print): _____ **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.**