Release of Information *You may complete a separate release for each sending/receiving location, or you may leave the Name of Sending/Receiving Location blank, authorizing reuse of release as necessary.*

Marshall Location • PO Box 26 Marshall, MN 56258 • Phone (507) 537-4525 • Fax (507) 929-4673 • office@hopeharbormn.org •
Winona Location • PO Box 353 Winona, MN 55987 • Phone (507) 474-6411 • Fax (507) 474-6415 • winona@hopeharbormn.org •

Client Information

_____ _____ _____
Full Name *DOB* *Phone*

_____
Address, City, State, Zip

Preferred Placement Location (circle one) Marshall, MN Winona, MN

Release Authorization

_____ _____
Individual Granting Permission for Release (if different from client) *Title or Relationship to Client*

_____ _____
Phone (if different from above) *Email*

I hereby authorize Hope Harbor to: ☐ Send to ☐ Receive from

_____ _____ _____
Name of Outside Sending or Receiving Location *Phone* *Fax*

_____
Address of Outside Sending or Receiving Location (include City, State, Zip)

Scope of Release Information received by Hope Harbor will be used for the following purposes: determining eligibility for placement, planning appropriate treatment or program, continuing appropriate treatment or program, case review

Permission Granted For (check here for all) ☐ Permission for release of all areas including tests, forms, reports, etc.
OR ☐ Academic testing results ☐ Psychological testing results/reports ☐ Individualized Education Plan
☐ Service plans ☐ Medical reports ☐ Other, specify:

Notes or Limitations _____

Disclaimer for Authorization and Signature I authorize the release of my confidential protected information, as described above.

- This authorization is voluntary, and refusal to sign will not jeopardize my right to obtain treatment.
- Information disclosed is protected by state and federal law, and use/disclosure is to conform to my directions.
- I may revoke authorization at any time in writing, except to the extent action has already been taken.
- Information used/disclosed in this authorization may be re-disclosed by recipient and may no longer be protected by federal privacy regulations, unless recipient is covered by laws that limit use/disclosure of my information.
- I understand legal and ethical requirements that mandated reporters take action in situations prescribed by law to report.
- I understand what information will be given, its purpose, and who will receive it.
- I understand I have a right to receive a copy of this authorization.
- A legal guardian or court appointed representative must attach a copy of authorization to receive this protected information.
- I understand that Hope Harbor is not a covered entity under HIPAA and is not required to be HIPAA compliant.
- I understand that Hope Harbor can request information from HIPAA covered entities, and that covered entities can release information via fax or ground mail. HIPAA protected Information may not be shared via email.
- Covered entities may also require that I sign their own HIPAA compliant releases before releasing information.

_____ _____ _____
Signature *Title or Relationship* *Date*

Release expires one year after end of client's treatment unless otherwise revoked. Information has been disclosed from confidential records. Further disclosure without the specific written consent of client exceeds the limits of this release. Revised 1/2018 mab