

Dual Recovery Program Authorization to Disclose Protected Health Information

610 Florence Avenue Owatonna MN 55060 Ph: 507-451-2630 Fax: 507-444-2251

For ongoing/multiple releases OR if request is from someone other than the client or their legal representative (a fee may be charged)

CLIENT NAME		Date of Birth	Client #
Your Name Here		12/15/2020	- Annual Control of the Control of t
List SCHRC as my providers and payers ⊙ Yes ○ No	der in a Record Locator	Enter your Baservice for my other	rthdate
Please □ Send □ Request ☑ Ex	change		
my information to/from/whospitals), or general des First and Last Name of Pa	scription (such as "any o	the state of the s	on (such as
Address (optional)		- Annual	
Address Line 1			
Address Line 2	ï :		
		Accordance of the Control of the Con	
City	State	Zip Code	
Phone (optional) (555) 555- 5555 Enter Parent (1997)		ct address (optional)	
Email (optional)			

Information to be Released (required)

By indicating any of the categories below, you are giving permission for written information to be

released **and** for a person at SCHRC to talk to a person in the **to/from/with** description above unless you indicate otherwise in the **"Other"** box below.

Time period of r	ecords to be re	<u>leased:</u>	
☑ All dates	OR s _l	pecific dates/years of treatment	
Specify what inf	ormation is to	oe released:	
☑ All informatio	pelom	may choose what you want released	
To only release : □ Assessment/E	valuation □ Pro t □ Labs/Meds/	ogress Notes □ Testing Results □ Letter(s) □ Verbal Information □ /Allergies □ Admission/Discharge/Transfer Alerts □ Continuity of Care	
Other (specify w	hat other infor	mation or documents)	
		s special consent by law. Even if you indicate all information , you must in order for it to be released:	
Dual Recovery P ☑ Chemical depe		or chemical dependency treatment records า	
Reason (required) ○ Assessment and Treatment Planning O Continuity of Care		Other reason (e.g., legal, appeal SS Disability, marketing, etc.)	
Valid for: (required)	☑ One year	or until this other event: (ex: one month after signature, case closure, 5 years after case	
This authorization date I sign this for one of the one		closure, etc.) Information placed in my record after the	

- I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.
- I understand that I have the right to revoke this authorization by signing "I revoke..." below and returning the form to SCHRC. If SCHRC has already released information based on this consent, we cannot retrieve what has already been released.
- I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient, and SCHRC can no longer protect it.

• I understand that I may refuse to sign this consent, if I so desire, and that SCHRC may not refuse treatment if I do not sign, but refusal may have consequences that have been explained to me.

Signature	
Client Signature	Date
<u> </u>	12/15/2020
J 19n	
If not the client, indicate if you are parent or persolegal proof before signing if not parent)	onal representative (provide
Parent/Guardian Signature	Date
Email	Legal Proof
To receive confirmation of receipt from SCHRC and to ma yourself	ke á copy for
To revoke this authorization, s	ign here and return to SCHRC
Signature to revoke	Date

*** Attention: Any Release completed for SCHRC is valid across all programs of SCHRC, except for our chemical dependency program - you must check that box for that information to be included ***

Below are samples of needed Authorizatons to be filled out for the Dual Recovery Program - 1 of each type shown below to MN Adult Abuse Reporting Center, Self, and SCHRC