SOUTH CENTRAL HUMAN RELATIONS CENTER

Providing Direction for Life's Problems Since 1964

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

Your Name Here

Date of Birth

12/15/2020

Enter Your Birthdate

Client #

List SCHRC as my provider in a Record Locator Service for my other providers and payers

⊙ Yes ○ No

Please

☐ Send ☐ Request ☑ Exchange

my information to/from/with - Specify a name, organization, type of organization (such as hospitals), or general description (such as "any care provider")

Minnesota Adult Abuse Reporting Center

Address (optional)

Address Line 1

Address Line 2

City

State

Zip Code

Phone (optional)

(844) 880-1574

Fax (optional)

HIE/PHR/@direct 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 records to be released:

☑ **All dates** **OR specific dates/years of treatment**

Specify what information is to be released:

☑ **All information**

OR

To only release specific information:
☐ Assessment/Evaluation ☐ Progress Notes ☐ Testing Results ☐ Letter(s) ☐ Verbal Information ☐ PSI/Police Report ☐ Labs/Meds/Allergies ☐ Admission/Discharge/Transfer Alerts ☐ Continuity of Care Document (CCD) ☐ Healthcare Provider Portal

Other (specify what other information or documents)

*The following information requires special consent by law. Even if you indicate **all information**, you must specifically request the following in order for it to be released:*

Dual Recovery Program (DRP) or chemical dependency treatment records
☑ Chemical dependency program

Reason (required)
◯ Assessment and Treatment Planning
Continuity of Care

Other reason (e.g., legal, appeal SS Disability, marketing, etc.)
Release suspected maltreatment

Valid for: (required) ☑ **One year** **or until this other event:**

(ex: one month after signature, case closure, 5 years after case closure, etc.)

This authorization extends to information placed in my record after the date I sign this form.
⊙ Yes ○ No

- *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

12/15/2020

If not the client, indicate if you are parent or personal representative (provide legal proof before signing if not parent)

Parent/Guardian Signature

Date

Email

To receive confirmation of receipt from SCHRC and to make a copy for yourself

Legal Proof

To revoke this authorization, sign 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