SOUTH CENTRAL
HUMAN RELATIONS CENTER
Providing Direction for Life's Problems Since 1964

Dual Recovery Program

Ph: 507-451-2630 Fax: 507-455-8133
610 Florence Avenue
Owatonna MN 55060

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form if the Client requests ongoing release OR if request is from someone other than the client or their legal representative

Client Name: ______________________ **D.O.B.:** ___/___/___ **Client #:** __________

I authorize South Central Human Relations Center to ***send*** ☑ ***request*** ☑ *the private data specified below to/from:*
(A fee may be charged)

Name/Entity/Category: Parent(s) Name(s) - Parent

Address ______________________ City ______________ State ______ Zip ______

Email: ______________________ Encrypted: ☐ I understand the risk and request unencrypted: ☐

Fax: ______________ Phone: ______________ HIE/PHR ______________

Information to be Released: Ongoing ☐ or Date from ________ to ________ or specific visit date: ________

Check what you want released

- ___ Assessment/Evaluation
- ___ Progress Notes
- ___ Letter(s)
- ___ Continuity of Care Doc (CCD)
- ___ Testing Results
- ___ Verbal Information
- ___ Healthcare Provider Portal
- ___ PSI/Police Report
- ___ Admission/Discharge/Transfer Alerts
- ✓ Other (specify) billing and attendance information
- ___ Labs/Meds/Allergies

You must specifically request the following for it to be released:

- ✓ Chemical Dependency Program
- ___ Psychotherapy Notes (conversational analysis) No other items can be checked when requesting this item

Reason: ___ Assessment and Treatment Planning ✓ Continuity of Care
✓ Other (specify, e.g. legal, appeal SS Disability) billing and attendance information

Valid for: One year ☑ **or for this specified period:** ______________

This authorization **does** ☑ **does not** ☐ extend to information placed in my record after the date I sign this form.

- *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 to SCHRC. If South Central Human Relations Center 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:

____ ______________
Indicate if you are: Client, Parent, or Personal Representative (Provide legal proof if representative not parent) Date

____
Type of identity verification

I **revoke** this authorization: ______________________________ ___/___/___
Signed Date