WOODLAND CENTERS

Client Name: _____

Date of Birth: _____Case #_____

I authorize Woodland Centers: to _____ Exchange with OR _____ Disclose to OR _____ Obtain from

Name of Organization or Individual: _____

Mailing Address: _____

City/State/Zip: _____Telephone #:_____FAX #:_____

The information is necessary for the following purpose:

_____ Evaluation/Treatment _____ Per Client Request _____ Per request of above-identified family member
_____ Financial/Billing _____ Other

_____

Information to be released (circle Yes or No):

YES	NO	Evaluations and Notes/Summaries including Psychiatric/Psychological/Medical/Chemical Dependency
YES	NO	Service Dates
YES	NO	Court/Corrections Information
YES	NO	School or Educational Info (may include academic progress, behavior issues, or special education data)
YES	NO	Social Services Agency Information
YES	NO	Other (specify) _____

I UNDERSTAND:

- This information may include chemical dependency information.
- I have the right to revoke this authorization at any time by giving written notice to Health Information Management Services. I understand the revocation will not apply 1) to information that has already been released in response to this authorization or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
- I need not sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party (i.e., consultation).
- Woodland Centers cannot prevent the redisclosure of records released as a result of this request, and after the information is released from Woodland Centers, the records may not be subject to privacy rule protections.
- This authorization will permit two-way telephone communication and exchange of information by electronic transmission.
- I am entitled to a copy of this authorization once I have signed it. I may review/request copies of information disclosed.
- A photocopy or facsimile of this authorization is as effective as the original.

This authorization shall remain in effect until the following date: _____ (Five year maximum. If no date is indicated, the authorization expires one year from date signed. This authorization will permit disclosure of past,current, and future records,up until the expiration date.)

_____ _____ _____ _____
Client Signature Date Witness Signature Date

_____ _____ _____
Parent/Guardian Signature Relationship to Client Date

A copy of this authorization to obtain information was sent to the above agency on (Date) _____by_____.
Information should be sent to Woodland Centers, Attention: _____ at:

___ Box 787, Willmar, MN 56201 ___ Box 55, Litchfield, MN 55355 ___ Box 187, Montevideo, MN 56265
___ Box 493, Dawson, MN 56232 ___ Box 84, Olivia, MN 56277 ___ 1209 Pacific Avenue, #104, Benson, MN 56215

Or FAX to: _____

For office use only: Entered By: _____ Date: _____