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 #:**_____

Reason for Release:

- ☐ **Coordination of Care**
- ☐ **Per Client Request**
- ☐ **Per request of above-identified family member**
- ☐ **Financial/Billing**
- ☐ **Legal**
- ☐ **Other** _____

Information to be Released:

- ☐ **Specific dates/years of treatment** _____ (if not indicated, the release of past, present, and future records will be permitted)
- ☐ **Any/All Records (Includes ALL records listed below, excluding substance use program records unless specifically indicated below)**
- ☐ **Summary of Services (Includes Discharge Summary, History/Physical, Consultations, and Test Results)**
- ☐ **Mental Health Evaluations (Including Psychological Testing)**
- ☐ **Treatment Plan/Functional Assessment**
- ☐ **Progress Notes/Office Visits**
- ☐ **Medications**
- ☐ **Lab/Radiology Reports**
- ☐ **Legal/ Court/ PO**
- ☐ **School Records**
- ☐ **Social Services**
- ☐ **Verbal Only (No Records)**
- ☐ **Other (Specify Content):**_____

SPECIFIC AUTHORIZATION FOR RECORDS PROTECTED UNDER 42 CFR PART 2: (this includes records pertaining to SUD and/or Detox Programs):

- ☐ **Substance Use Disorder/Chemical Dependency Records**

I UNDERSTAND:

- **Records may include information regarding treatment for alcohol or drug abuse.**
- **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: _____ (If no date is indicated, the authorization expires one year from the date signed.)

_____ _____ _____ _____

Client Signature **Date** **Witness Signature** **Date**

_____ _____ _____

Parent/Guardian Signature **Relationship to Client** **Date**

Information should be sent to Woodland Centers, Attention: _____ **at:**

- ☐ **Box 787, Willmar, MN 56201**
- ☐ **Box 493, Dawson, MN 56232**
- ☐ **Box 145, Ortonville, MN 56278**
- ☐ **Box 55, Litchfield, MN 55355**
- ☐ **Box 84, Olivia, MN 56277**
- ☐ **Box 187, Montevideo, MN 56265**
- ☐ **1209 Pacific Avenue, #104, Benson, MN 56215**

Or Fax to: _____ **For office use only: Entered By:** _____ **Date:** _____

Directions for Completion of Form

Patient Information: Please indicate the name of the client whose records are to be released, including date of birth. (Woodland Centers' staff will enter the Client ID number)

"Exchange", "Disclose", or "Obtain": If you indicate "Disclose to" , Woodland Centers will not be able to receive any records from the organization and if you choose "obtain from" Woodland Centers will not be able to release information to this particular organization. Choosing "Exchange with" will allow Woodland Centers to disclose AND obtain records.

Reason for Release: Please indicate the reason records are to be released. This helps establish priority of the status of the release. It also helps determine who is responsible for the cost of records (when appropriate).

Information to be released: In this section you will choose which information can be released. You have an opportunity to be as specific as you would like. For example, if you want only a specific date range released, you must indicate in this section. If no date is written, Woodland Centers will have permission to send any records from the past, present, and future up until the release expires. If you chose Any/All records, Woodland Centers will be able to send any information from your record including all programs, ***with the exception of Substance Use Disorder Treatment or Detox records, which needs to be specifically indicated***.

Specific Authorization for Records Protected under 42 CFR Part 2: If you have received treatment for a Substance Use Disorder/Chemical Dependency, or if you have been admitted to our Detox center, this box needs to be checked to send any information regarding that treatment, even if you selected "Any/All Records" above.

I Understand: This section explains the terms of the Authorization you are signing. Please read these terms carefully before signing this form.

Expiration Date: In this section you will decide when you would like the release to expire. For example, you may wish to give a longer expiration date for ongoing contact with other agencies (i.e. primary physicians, group homes, schools, and social services) such as 5 years. It is recommended that all other releases expire in one year (i.e. attorney, employer, family members, Substance Use Program) due to changes in circumstances and family dynamics. ROIs for minors should expire on or prior to their 18th birthday. ***If you do not indicate a date, the authorization will automatically expire one year from the date it was signed.*** If you wish to edit or revoke this form before the expiration date, please contact Health Information Management Services or the Privacy Officer.

Signature: Please sign AND date this form to validate this authorization. If this form is signed by someone other than the patient or parent, you will be required to provide proof of your authority (i.e. court order). A witness signature indicates who explained to the client or parent/legal guardian and/or helped complete the form.

PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING OF THE RELEASE OF INFORMATION. IN SOME CASES IT CAN TAKE UP TO 30 DAYS (45 CFR 164.524 (b)(2)(i).

For questions or concerns regarding this form please contact the Health Information Management office at (320) 231-9156.

Completed Authorization to Release Protected Health Information may be sent to:

Health Information Management Services (HIMS)
Woodland Centers
PO Box 787
Willmar, MN 56201

Or

FAX: (855) 625-7406