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 ________________________________

Records from the Following Dates: ☐ All (Including Past, Present, Future) ☐ Specific date(s) ____________ to ______________

Information to be Released (please mark appropriate boxes):

- ☐ 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: (includes records pertaining to SUD treatment and/or Detox Programs):

- ☐ Substance Use Disorder/Chemical Dependency Records

I UNDERSTAND:

- Records may include information regarding treatment for alcohol or drug abuse.
- I authorize the release to include records occurring prior to and past the date of signature, until the authorization expires or is revoked, unless I have specified a date range (see above).
- I have the right to revoke this authorization at any time by giving written notice to Health Information Management Services. Revocation will not apply to records that have already been released.
- I need not sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party.
- 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:

- ☐ Big Stone Center: 28 2nd St NW, PO Box 145 Ortonville, MN 56278 :: 320-839-8322 Fax: 855-867-8780
- ☐ Chippewa Center: 1234 E Hwy 7, PO Box 187 Montevideo, MN 56265 :: 320-269-6581 Fax: 320-269-7045
- ☐ Kandiyohi Center: 1125 SE 6th St, PO Box 787 Willmar, MN 56201 :: 320-235-4613 Fax: 855-625-7406
- ☐ Lac qui Parle Center: 669 6th St, PO Box 493 Dawson, MN 56232 :: 320-769-4864 Fax: 855-275-1310
- ☐ Meeker Center: 114 N Holcombe Ave, Suite 230, PO Box 55 Litchfield, MN 55355 :: 320-693-7221 Fax: 855-825-0812
- ☐ Renville Center: 902 W Lincoln Ave, PO Box 84 Olivia, MN 56277 :: 320-523-5526 Fax: 855-675-6425
- ☐ Swift Center: 1213 Pacific Ave, Benson, MN 56215 :: 320-843-2061 Fax: 855-482-7868
- ☐ Tri Star ACT: 215 Milkyway St S, PO Box 577 Cosmos, MN 56228 :: 320-877-7220 Fax: 320-877-7479

For office use only: Entered by: __________
Date: __________

Directions for Completion of Form. PLEASE COMPLETE ALL AREAS OF THE AUTHORIZATION TO ENSURE PROPER AND TIMELY DISCLOSURE OR RELEASE OF YOUR HEALTH INFORMATION.

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).

Records from the following date: Please choose "All" or specify a date or date range of records you would like released.

Information to be released: You may choose which records you want sent to include any and all records or pick specific information within your records to be released. 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. ***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