AUTHORIZATION FOR RELEASE OF INFORMATION

ANNE CARLSEN
HEALTH INFORMATION SERVICES

Anne Carlsen will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization

Name of Client (Last, First, Middle Initial)	Office Use Only MRN		Date of Birth
Street Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE *(to include verbal, written, and/or electronic exchange of information)*

I Hereby Authorize:

Name of Person/Organization	Email or Fax #		Phone
Address	City	State	ZIP Code

Permission To: ☐ Disclose To ☐ Obtain From ☐ Mutually Exchange With

Name of Person/Agency	Email or Fax #		Phone
Street Address	City	State	ZIP Code

Information to be Released

Service Programs: (Select all that apply) Service Dates From:_____ To: _____

☐ Behavioral Health/Autism Services ☐ Early Intervention ☐ Residential Services
☐ Mental Health Therapy ☐ Therapy Services (Speech, OT, PT) ☐ Education Services
☐ CommunityBased Services (Day/Residential/Independent Habilitation, Employment Programs, In-Home Supports)

The Following Information is Requested: (Select all that apply)

☐ Social History and/or Updates ☐ Behavior Program ☐ Progress Notes
☐ History and Physical Reports ☐ Immunization Records ☐ Educational assessments/Testing
☐ Guardianship/Custody/Legal ☐ Discharge Orders/Summary ☐ Quarterly Reports
☐ Psychological Reports Evaluations ☐ Psychiatric Evaluation Notes ☐ Dental Reports
☐ Specific Consult Report or Other (Be specific, i.e. date, physician, etc.):

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV-RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records: (indicate and also initial record type authorized)

☐ Chemical Dependency _____ ☐ Psychiatric/Mental Health _____ ☐ HIV/AIDS-related Content _____

The information identified above will be used for: (Select all that apply)

☐ Coordination of Services/Continuity of Care ☐ Legal ☐ Other (must specify to be valid)
☐ Insurance/Billing/Payment ☐ Personal

CLIENT CONSENT

The authorization remains in effect for one year from date signed unless a different expiration date/event is entered here:_____

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage, I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Signature of Client		Date
Signature of Parent/Guardian or Custodian (if needed)	Relationship	Date

Phone: 701.751.3732 Fax: 855.368.8592 Email: ROI@annecenter.org

Instructions for Anne Carlsen Release of Information Form

Individual's full/complete name. If there is a suffix after the name, please provide it in the space along with the last name.

Individual's date of birth.

Individual's full/complete address.

Client Release and Signature

I Hereby Authorize: The name or other specific identification of the person, agency or class of persons, authorized to disclose the information and complete mailing address.

Permission To: The name or other specific identification of the person, agency or class of persons authorized to receive the information and complete mailing address. Provide an Email address if Email delivery is requested.

Special Information Regarding Email Delivery: Anne Carlsen is committed to safeguarding information in transit. Protected health information, confidential information and client specific information will only be sent by secure Email to persons/agencies outside of Anne Carlsen when requested.

Information to be Released: Provide a detailed description of the information to be disclosed, including how much and what kind of information. If the information is limited to specific date(s), please include this information. Statements such as “All my information” or “My entire record” are acceptable.

Special Authorization: Chemical Dependency, Psychiatric/Mental Health and HIV/AIDS-related records will not be released unless specifically authorized in writing.

Request Reason: Select the reason(s) why the information is being disclosed.

Client Consent

Enter the date the authorization is to expire. If left blank, the authorization will expire one year from the date it is signed.
Sign and date the form. Anne Carlsen may request individuals provide proper identification.
If you are a legal representative, sign, date and indicate your relationship to the individual.

- **Please note:** If the form is signed by a legal representative such as a guardian or custodial agency, a copy of the legal documents verifying the legal representative's authority must be on file at Anne Carlsen or attached to this form.

- **Minors:** North Dakota law requires a minor 14 years of age or older, to authorize the disclosure of sexually transmitted disease and substance use disorder treatment information. Disclosure of sexually transmitted disease or substance use disorder treatment information of a minor 13 years of age or younger, must be authorized by BOTH the minor and the parent/legal guardian.

Send ROI to:
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