WOODLAND CENTERS

Client Name: _____

Date of Birth: _____Case #:_____

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

Name of Organization & Individual:_____

Mailing Address: _____

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

The information is necessary for the following purpose:

_____ Evaluation/Treatment
_____ Financial/Billing
_____ Per Client Request
_____ Per request of above-identified family member
_____ 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 Information (may include academic progress, behavior issues, or special education data)
YES NO Social Services Agency Information
YES NO Other (specify)_____

I UNDERSTAND THAT:

* 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 that after release 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 and 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: _____ (one year maximum)

_____ _____ _____ _____
Client Signature | Date | Witness Signature | Date

_____ _____ _____
Parent/Guardian Signature | Relationship to Client | Date

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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 75, Atwater, MN 56209
_____ Box 55, Litchfield, MN 55355
_____ Box 493, Dawson, MN 56232
_____ Box 187, Montevideo, MN 56265
_____ Box 84, Olivia, MN 56277
_____ 1209 Pacific Avenue, #104, Benson, MN 56215

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

~~UPDATE:~~

Signature: | Date Signed: | Date Expires: | Entered By:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____