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