



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
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Parent/Guardian Signature	Relationship to Client	Date
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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

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.*** PLEASE NOTE: Some agencies will not send records past the date which the authorization is signed. To ensure the exchange of pertinent information, please make sure to mark the box “I authorize release of the information listed below to include records dated prior to and past the date of signature”.

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