Northern PSYCHIATRIC ASSOCIATES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Other Name(s) Used: _____

I authorize Northern Psychiatric Associates to **RELEASE** to: _____

Address: _____

I authorize Northern Psychiatric Associates to **RECEIVE** from: _____

Address: _____

_____Any and all medical records, _____ OR, any and all medical records dated from _____ to _____ OR, selected records as indicated below:

_____ History and Physical

_____ Consultation(s)

_____ Progress in Treatment

_____ Psychiatric Diagnostic Evaluation

_____ Alcohol and Chemical Dependency Evaluation Findings and Recommendations

_____ Emergency Department Records

_____ Laboratory Results

_____ Discharge Summary

_____ Other: _____

These records are required for the purpose(s) of:

_____ Continued/follow-up care

_____ Claim payment/Insurance benefit consideration

_____ Other: _____

_____ EAP/Employer Coordination

_____ Social Services Involvement

_____ Court/legal action

This authorization will remain in effect a maximum of **12 months** from the date of signature and may be cancelled by me in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact Northern Psychiatric Associates at (218) 454-0090. **I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. This information may be disclosed to and used by the individual or organization listed above.**

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____ Witness: _____