SUBSTANCE USE DISORDER RELEASE OF INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd. and Family Support Services, Inc.

Address: _____

City / State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

To do the following:

☐ **Release to**
☐ **Receive from**

Agency/Name: _____ Phone: _____

Address: _____ City: _____ Fax: _____

State: _____ Zip: _____ Email Address: _____

Information to be Released

(What do you want sent or released?)

Check appropriate box(es):

Only release Substance Use Disorder records checked below

- ☐ Substance Use Disorder Comprehensive Assessment/Rule 25
- ☐ Letter of Recommendation
- ☐ Verification of Attendance Letter
- ☐ Substance Use Disorder Diagnostic Assessment (Mental Health DA)
- ☐ Progress Notes/Treatment Plan Reviews
- ☐ Discharge Summary
- ☐ Oral Communication
- ☐ Other: _____

NOTE: Unless otherwise indicated, all related records regarding Mental Health and Substance Use Disorder will be included. This does not include records legally defined as Psychotherapy notes.

Or

- ☐ All Substance Use Disorder Records Dated from: ____ to ____
- ☐ Any/All Substance Use Disorder Records

Purpose of Release

(Why is it needed?)

Check appropriate box(es):

The purpose of this release is for coordination of care, or:

- ☐ Personal Use/Review
- ☐ Social Security appeal /disability
- ☐ Other: _____
- ☐ Insurance payment/claim
- ☐ Litigation/legal
- ☐ Family Involvement
- ☐ Collateral Information

NOTE: Purpose for release is not required if you are requesting your own records for personal use/review. Records sent to third party must identify a purpose.

Method of Communication

(How would you like your information communicated/sent?)

Check appropriate box(es):

Electronic Methods:

- ☐ Standard email (PDF)
- ☐ Secure Email (PDF)
- ☐ FollowMyHealth (Requires FollowMyHealth account)
- ☐ CD (Password Protected PDF)

NOTE: Transmission of records via standard email is not a secure method of transmission. By choosing email,

Standard Methods:

- ☐ Phone/Email Conversation
- ☐ Fax
- ☐ Pick up
- ☐ Mail

Initial Action

(What would you like done with the release?)

- ☐ Keep On File — For Future Use
- ☐ Send Records — To Agency/Name Listed Above
- ☐ Request Records — From Agency/Name Listed Above

NOTE: If nothing is checked, release will be placed on file for future requests.

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Re-disclosure of these records is prohibited without the written consent of the client.

Patient Signature: _____ **DATE**: _____

Or legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

NOTE: If signed by someone other than the patient, we need written proof of authority.

For internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Release of Information

Nystrom & Associates, Ltd. (NAL) recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL with any questions concerning this form at the below listed offices or website.

Required Fields: In order for the release of information to be HIPAA compliant, please ensure all fields inside the bolded box are filled out. Finally, ensure the release is signed and dated.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

To Do the Following: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check either: (1) Release to, and/or (2) Receive from, If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to indicate what information you wish to be shared. Please select the appropriate box or write in date range. Selecting Any/All authorizes NAL to share or send your entire medical record.

Method of Communication: Use this space to indicate what method you would like records transmitted. If you would only like NAL/FSSI to have verbal communicate with the identified person/agency, select the Verbal/Phone option. If you wish records to be transmitted to the person or agency, select one of the other available options. If you are requesting a copy of your own records, we encourage you to use one of the available electronic methods so you can quickly and easily get access to your records.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. Unless otherwise noted this consent will automatically expire in one year from the date signed.
The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ If requesting records, 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 your NAL facility listed below.