SUBSTANCE USE DISORDER RELEASE OF INFORMATION

CO-OCCURING SUBSTANCE USE DISORDER PROGRAM

Initial Action
(What would you like done with the release?)

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

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

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd.

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____ Phone: _____

To do the following:

☐ **Release to**
☐ **Receive from**

Agency/Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

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
- ☐ 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

Method of Communication
(How would you like the information communicated/sent?)

Check appropriate box(es):

Electronic Methods:

- ☐ Standard email (PDF)
- ☐ Secure Email (PDF)
  Email Address: _____
- ☐ 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, I understand that I risk my information being intercepted by an unauthorized individual.

Standard Methods:

- ☐ Verbal/Phone
- ☐ Fax
- ☐ Pick up
- ☐ Mail

Purpose of Release
(Why is it needed?)

Check appropriate box(es):

- ☐ Coordination of Care
- ☐ Social Security appeal
- ☐ Social Security disability
- ☐ Insurance payment/claim
- ☐ Litigation/legal
- ☐ Personal use/review
- ☐ Other: _____

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

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**: _____

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.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.

For Internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Authorization for Releasing of Confidential 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.

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.

Minneapolis/St. Paul
Brighton Professional Building
1900 Silver Lake Road, Suite 110
New Brighton, MN 55112
P (651) 628-9566
F (651) 628-0411

Apple Valley
Merchants Bank Building
7300 West 147th Street, Suite 204
Apple Valley, MN 55124
P (952) 997-3020
F (952) 997-3026

Big Lake
207 Jefferson Blvd
Big Lake, MN 55309
P (763) 367-6080
F (763) 263-7897

Bloomington
1101 E 78th Street, Suite 100
Bloomington, MN 55420
P (952) 854-5034
F (952) 854-5363

Brainerd/Baxter
13045 Falcon Drive
Suite 100
Baxter, MN 56425
P (218) 829-9307
F (218) 829-7649

Cambridge
817 N Main Street
Cambridge, MN 55008
P (763) 325-0300
F (763) 325-0301

Coon Rapids
11660 Round Lake Blvd NW
Coon Rapids, MN 55433
P (763) 767-3350
F (763) 767-0912

Duluth
Providence Building
332 West Superior Street, Suite 300
Duluth, MN 55802
P (218) 722-4379
F (218) 722-4333

Eden Prairie
Prairie Lakes Corporate Center II
11010 Prairie Lakes Drive, Suite 350
Eden Prairie, MN 55344
P (952) 746-2522
F (952) 746-0887

Elk River/Otsego
9245 Quantrelle Avenue
Otsego, MN 55330
P (763) 746-9492
F (763) 746-3685

Maple Grove
13603 80th Circle North
Maple Grove, MN 55369
P (763) 274-3120
F (763) 274-3121

Minnetonka
Riverview Office Center
13100 Wayzata Boulevard,
Suite 200
Minnetonka, MN 55305
P (952) 206-2040
F (952) 206-2041

Rochester
401 16th Street SE, Suite 100
Rochester, MN 55904
P (507) 516-0030
F (507) 516-0031

Sartell/ St. Cloud
101 Dehler Dr
Sartell, MN 56377
P (320) 253-3512
F (320) 253-1037

Woodbury
Woodbury Plaza Office Building
1811 Weir Drive, Suite 270
Woodbury, MN 55125
P (651) 714-9646
F (651) 714-9647