NYSTROM & ASSOCIATES, LTD.

SUD Telehealth Consent Form

By signing this form, I understand the following:

1. I understand that the information and patient rights outlined in the Notice of Privacy Practices (NPP) continue to apply to me during tele-therapy.

2. I understand that in some cases the information transmitted may not be sufficient due to deficiencies or failures of the equipment or internet connection.

3. I understand that the laws to protect privacy and the confidential of medical information also apply to telehealth and that no information obtained in the use of telehealth will be disclosed without my consent. NAL has security and safeguards in place to protect such information; however, NAL cannot be responsible for any information that is disclosed on my end for lack of privacy at the location I am receiving services.

4. I understand that disclosure of the location I chose to conduct therapy online is required and if the location changes, it is the patient's responsibility to notify the provider to ensure compliance with State regulations. This is in place to ensure that appropriate emergency contacts/providers are accessible in the event of an emergency.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that results cannot be guaranteed or assured. Additionally, I understand that telehealth may not be as effective as face-to-face services and if my provider believes another form of services would better serve me; my provider may refer me to seek a provider who can provide such services in my area.

Attestation for Consent: I have read and agree to the terms of NAL telehealth services. I hereby give my consent for the use of telehealth in my treatment.

Counselor's Clinic Location: _____

Client's Location:_____

Printed Name:_____ Date of Birth: _____

Signature of Patient:_____ Date: _____

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
202 Ashland Street South
Cambridge, MN 55008
P (763) 325-0300
F (763) 325-0301

Coon Rapids
Coon Rapids Professional Building
3833 Coon Rapids Blvd, Suite 120
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

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT 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: 1900 Silver Lake Rd NW #110 Fax: 651-604-5905 City: New Brighton State: MN Zip: 55112 Phone: 651-628-9566
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 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 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 ☐ Other: _____ ☐ Insurance payment/claim ☐ Litigation/legal ☐ Personal use/review **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: _____

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Information to be Released (What do you want sent or released?) Check appropriate box(es):	**Only release 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 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 ☐ Other: _____ ☐ Insurance payment/claim ☐ Litigation/legal ☐ Personal use/review **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.

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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: _____

Substance Use Evaluation

Client Privacy Rights - Tennessen Notice

Information about your rights under the Minnesota Data Practices Act: The Minnesota Government Data Practices Act, Minn. Statute Chapter 13, (hereinafter "Data Practices Act") seeks to protect the privacy of the individuals about whom government agencies, their subdivisions, and agencies under contract with them collect data. The Minnesota Government Data Practices Act also facilitates the release of information that is public. The information on this sheet applies to your current and future contacts with this agency, whether the contact is in person, by mail or by phone.

The Data Practices Act requires that whenever we ask you to provide us with private or confidential information about yourself that you be told:

- The purpose and intended use of the data within this agency;
- The legal requirements, if any, of providing the information;
- The legal consequences of providing or refusing to provide the information requested; and
- The identity of other persons or agencies authorized by statute to receive the information.

Purposes: The purposes of the information we collect from you are listed below. Because this list of purposes covers a variety of programs, some of the purposes listed may not apply to you. Details about the purposes of the information we collect from you are often listed on the forms you are asked to complete. Depending upon the program you are in, the data we collect from you may be used for the following purposes:

- To comply with any court ordered with any court ordered treatment
- Determine your eligibility for assistance or services provided by this agency
- Provide effective care and treatment of medical/social/psychological problems
- Establish the amount of financial aid for which you are eligible
- Enable us to collect federal, state or county funds for assistance and services for you and your family
- Determine your ability to pay for medical treatment or other assistance and services provided to you or to other person for whom you are responsible
- Collect reimbursement from other agencies or individuals for services or assistance we give you
- Obtain school assistance authorized by law
- Investigate complaints or reports of abuse, maltreatment, neglect, fraud or misconduct
- Investigate facility complaints
- Ascertain applicant's eligibility for adoption services
- Conduct program and financial audits
- Determine whether you or your children need protective services

During the time we will be involved with you, we will be asking you information about your physical health, your mental and emotional health, your chemical use, your living situation and employment, your finances, and/or your relationships. We only ask for information that we are authorized by law to have that will help us provide you with appropriate services.

Minors: If you are a minor, you have the right to request that private data about you be kept from your parents. You must make this request in writing. You must explain why you wish this data be withheld and what you expect the consequences of sharing the data with your parents would be. If the agency agrees withholding the information from your parents is in your best interests, the data will not be shown to your parents.

Substance Use Evaluation

Client Privacy Rights - Tennessen Notice

Sharing Information: There are other agencies that we are allowed by law to share information with if they need it for investigations, for background studies, for licensing actions, or to help you or help us to help you. Information will only be shared with those entities or organizations and anyone under contact with these entities or organizations once it is determined they need the information to perform their jobs. These may include:

- Service providers under contact with Nystrom & Associates, Ltd. to provide Rule 25 Substance Use Disorder Assessment services
- Service providers under contact with Nystrom & Associates, Ltd. to provide 245G Substance Use Disorder Treatment services
- US Department of Health and Human Services
- Social Securitiy Administration
- Minnesota Department of Human Services
- Minnesota Department of Health
- Local and State Law Enforcement
- Coroner or Medical Examiner
- County Attorney or Attorney General
- Internal Revenue Service
- Multidisciplinary Case Consulation Teams
- Minnesota Department of Revenue
- Other County Welfare or Human Services Agencies
- Court Officals
- Ombudsman for Mental Health & Mental Retardation
- Local Early Childhood Intervention Contacts
- Applicable school districts and service providers
- The Immigration and Naturalization Service
- Managed care orgranizations about your health care or benefits
- Insurance companies to check health care benefits for you or your family memebers
- Employees or volunteers of welfare agency who need the information to do their jobs
- Community Mental Health boards, state hospitals, state nursing homes, and or/entities under contract to one of these facilities, to the extent f the contract.
- Any other government agency that is authorized to have the information under state or federal law and has a need to know about the information

Other Rights

- You have the right to know what information is maintained about you.
- You have the right to view all public and private information about you maintained by this agency. This includes the right for you to authorize other persons or agencies to view it.
- You have the right to have data which you have access explained to you
- You have the right to request copies of the information which you have access. You may, however, be required to pay for the cost of those copies.
- You have the right to challenge the accuracy or completeness or any private information in your records. If you want to challenge any information, write to the responsible authority of the agency that has your records. You may also talk to person at this agency who works with you.
- You have the right to insert your own explanation of anything you object to in your records.

I acknowledge that I have received this notice that explains my privacy rights. If I have any questions or concerns, I can contact Nystrom & Associates, Ltd. Substance Use Disorder Program at 651-628-9566.

Client Signature: _____ Date: _____

Copy Provided/Initials _____