RELEASE OF CONFIDENTIAL BEHAVIORAL HEALTH, ALCOHOL AND/OR DRUG TREATMENT RELATED INFORMATION

PATIENT ____
(FIRST) (MIDDLE) (LAST) (MAIDEN OR OTHER NAMES USED)

DATE OF BIRTH ______________________ **PHONE NUMBER** ______________________
(MONTH) (DAY) (YEAR)

PATIENT ADDRESS ____

RELEASE TO/OBTAIN FROM (circle one)

Spectra Health
212 S 4th St Ste. 200
Grand Forks, ND 58201-4776

Medical/Dental PH# 701-757-2100
Medical Fax# 701-757-0305 Dental Fax# 701-757-2103

BHC - For Future Use or Verbal Consent Only.

RELEASE TO/OBTAIN FROM (circle one)

____
(Name of Health Care Provider/Plan/Other)

____
(Address)

______________ ______________ ______________
(Phone Number) (Fax Number) (Email Address)

The information may be communicated in the following manner:
________Verbal________Written________Electronic

The following information from the record of the above-named patient to be released (REL) or requested (REQ).

- ____ REL/REQ Addiction Assessment Summary
- ____ REL/REQ Transfer/Discharge Summary
- ____ REL/REQ Psychiatric Evaluation
- ____ REL/REQ Psychological Evaluation
- ____ REL/REQ Psychological Testing
- ____ REL/REQ Progress Notes
- ____ REL/REQ Legal Status
- ____ REL/REQ Verification of Treatment
- ____ Other (Specify) ______________________
- ____ REL/REQ Physical Exam
- ____ REL/REQ Laboratory Tests
- ____ REL/REQ Summary of Visits
- ____ REL/REQ History of Alcohol/Drug Usage and Behavior
- ____ REL/REQ Treatment Date, Discharge Status, and Recommendations
- ____ REL/REQ Results of Addiction Evaluation and Recommendations

The information is necessary for:

- ____ Diagnosis and Treatment
- ____ Follow up Treatment
- ____ Update Records
- ____ Family Involvement
- ____ Employment
- ____ Continuing Education
- ____ Collateral Information
- ____ Social Services Involvement or Insurance Investigation
- ____ Legal Proceeding
- ____ Other (Specify)______________________

Spectra Health acknowledges that the provision of the services is not contingent upon the client's decision concerning the release of this information. This consent is subject to revocation at anytime except to the extent that the program which is to make the disclosure has already taken action in reliance on it. A copy of this release is as effective as the original. If not previously revoked, this consent will terminate upon: ______________________________
(Specific date, event, or condition)

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Guardian, Parent or Authorized Representative Date

______________________________ ______________
Witness Date

NOTICE TO WHOEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Requested Provider: ______________ Sender Initials: ________

Date Sent: ______________ FAX/MAIL

PATIENT STICKER HERE