Authorization to Release and Disclose Patient Information

Initial Action: ☐ **Keep On File** Future Communication ☐ **Send Records** To Agency/Name ☐ **Request Records** From Agency/Name

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

Patient Information:
Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip code: _____

I or My Legal Guardian Authorize:

BLUESTEM CENTER FOR CHILD AND FAMILY DEVELOPMENT
124 Elton Hills Lane NW Phone: (507) 282-1009
Rochester, MN 55901 Fax: (507) 282-0932

To do the following:
☐ Release to
☐ Obtain from
☐ Exchange information

Agency/Name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____

Purpose of Release: ☐ **Evaluation/Treatment** ☐ **Coordination of Care** ☐ **Court/Legal** ☐ **Consultation** ☐ **Request of Individual or Guardian** ☐ **Other:** _____

Length of Authorization:
Expires in one year from date of signature unless another date is specified here: _____
☐ I authorize release of information and records regarding future care until authorization expires.
☐ I authorize ongoing exchange of information/communication between above parties until authorization expires. **Including**: ☐ via Telephone ☐ via Email ☐ In Person

Method of Disclosure: ☐ **Fax** ☐ **Pick up** ☐ **Mail** * **Information Needed by:** _____ *

Information to be released:

Mental Health Records: ☐ **All listed/as available** **From:** _____ **To:** _____
☐ Diagnostic assessment(s) ☐ 3 most recent progress notes ☐ All progress notes
☐ Treatment plan ☐ Treatment summary ☐ Psychological Testing/Reports
☐ **Other:** _____

NOTE:
- *This does not include records defined as psychotherapy notes.*
- *Per Bluestem Center policy, progress notes may be released at the discretion of provider.*

School Records ☐ **All listed/as available** **From:** _____ **To:** _____
☐ Child Study Team (Re)Evaluation ☐ IEP ☐ Behavior Plan
☐ Discipline Records ☐ Report Cards ☐ Attendance Records ☐ **Other:** _____

Medical Records ☐ **All listed/as available** **From:** _____ **To:** _____
☐ Clinic Notes ☐ Psychiatry/Psychology ☐ Neurology ☐ Behavioral health ☐ EKGs
☐ Lab Results ☐ Hospital discharge summary ☐ Genetics ☐ Radiology reports ☐ EEG reports
☐ Hospital notes ☐ Medication History ☐ **Other:** _____

Substance Use Disorder Records ☐ **All listed/as available** **From:** _____ **To:** _____
☐ Toxicology/Drug test results ☐ Chemical Dependency Assessment (Rule 25) ☐ Progress notes
☐ Prescription verification ☐ Discharge/treatment summary ☐ Treatment plan/review

NOTE: Records are protected per 42 CFR Part 2. Specific consent is necessary. These records may be released separately.

I understand that: My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Bluestem Center's Privacy Notice. · I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Bluestem Center's Privacy Notice outlines the procedure for revocation. · For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)]. · Communications resulting from this authorization will reveal that I received services at Bluestem Center. · Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. Other information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by Federal HIPAA rules.

Signature: _____ **Date:** _____

☐ **Patient** ☐ **Parent** ☐ **Legal guardian** ☐ **Foster parent** ☐ **Other:** _____

Printed name (if not patient): _____

☐ **Check if patient is 16-17 years old:** X Signature _____ **Date:** _____

Witness Signature: _____ Printed name: _____

Staff Use Only **Scanned:** **Faxed/Mailed:** **Records Released:**