Northland Counseling Center, 215 SE Second Avenue, Grand Rapids, MN 55744
218-326-1274 1-800-450-1274 Fax: 218-326-9787

Authorization for the Release of Medical Information

I, _____ **authorize**
(Name) (DOB)

Northland Counseling Center to: __x__ **Give information to**
(Check one or both) __x__ **Receive information from**

_____
(Outside Agency or Individual's Name)

Dates or Type of service to be released by mail, telephone, or facsimile as follows:

X	Diagnostic Assessment/CD Evaluation	X	Psychological Evaluation
X	Treatment Plan	X	Medical Report and Medication Regimen
X	Narratives/Progress Notes		
X	Educational Information	X	Discharge Summary
X	Other (specify) Verbal		

Records related to chemical dependency, mental health, sickle cell anemia, tuberculosis, and/or HIV/AIDS will be released, unless otherwise indicated by initialing here: _____

Approximate Dates of information requested: Current or most recent episode of care.

Purpose of Disclosure:

X	Coordination of Care and Services	_____	Legal
X	Future Referrals/References	_____	Disability Claims
_____	Other (specify) _____		

I understand that my authorization terminates one year from the date of my signature. I understand that I have the right to revoke this authorization in writing at any time prior to the termination date. I understand that NCC cannot release information disclosed by this authorization to anyone other than listed above, and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient only upon my written consent. I further understand that the information disclosed as a result of this authorization may no longer be protected and could be redisclosed by the recipient without my permission. NCC will not condition treatment on my signing this authorization. A copy of this authorization shall be considered as valid as the original.

_____ _____
Client/Guardian Signature **Date**

_____ _____
Witness **Date**

If signing as the authorized representative of the patient, I am: (please check one)
____ Court appointed guardian
____ Custodial parent of a minor
____ Other, explain_____

This information will be disclosed from your records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit 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 as 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.