NORTHLAND COUNSELING CENTER, INC.

ADULT INTAKE

DEMOGRAPHIC INFORMATION

Last Name:	First Name:	Middle Initial:	Date:
Address:	City:	State:	Zip:
Phone Number:	May we leave a voicemail? ☐ Yes ☐ No		May we text you? ☐ Yes ☐ No
Email Address:			May we email you? ☐ Yes ☐ No
Date of Birth:	Age:	Social Security Number:	
Gender at Birth: ☐ Male ☐ Female	Identified Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Other:		
Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other:			

Military Services:	☐ Non-Vet ☐ Vietnam Vet ☐ Other Vet ☐ Disabled ☐ Active Military Service **Branch:**
Race:	☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ More than one race ☐ Unknown ☐ American Indian/Alaskan Native, ***Tribe Enrolled***:
Ethnicity:	☐ Not Hispanic/Latino ☐ Hispanic/Latino (If yes, please select the following): ☐ Central American ☐ Cuban ☐ Dominican ☐ Puerto Rican ☐ South American ☐ Other:
Primary Language:	☐ English ☐ ASL ☐ Spanish ☐ Russian ☐ French ☐ Mandarin ☐ Other:
Secondary Language:	☐ English ☐ ASL ☐ Spanish ☐ Russian ☐ French ☐ Mandarin ☐ Other:

Hair:	Length: ☐ Short ☐ Medium ☐ Long	Height:
Eye color:	Do you wear: ☐ Glasses ☐ Contacts	Weight:

EMERGENCY CONTACT

Emergency Contact Name:	Relationship:
Address:	
Phone:	Email Address:
The emergency contact will ONLY be contacted in the case of an EMERGENCY. If you would like this person to have access to your records or to be able to schedule/cancel appointments for you, you MUST sign a Release of Information.	

GUARDIAN/POWER OF ATTORNEY

If you have a Guardian and/or Power of Attorney, please tell us the following information:	
Contact Name:	
Phone:	Email Address:
Role: ☐ Guardian ☐ Power of Attorney ☐ Other:	
If the client has a guardian or power of attorney, the guardian or power of attorney must sign all paperwork.	

REASON FOR YOUR VISIT

Tell us who referred you:	☐ Existing/Previous Client	☐ Self-Referred	☐ Probation
	☐ Health Care Provider	☐ Court	☐ Mental Health Provider
	☐ Employment Requirement	☐ Substance Use/Drug Court	☐ Other:

What services are you hoping to receive from Northland Counseling Center, Inc.? (*) Grand Rapids Only (**) I-falls Only

☐ Individual Therapy	☐ Family/Couples Counseling	☐ Diagnostic Assessment Only
☐ Adult Case Management	☐ Testing (ex. ADHD)	☐ ARMHS
☐ Kiesler Wellness Center*	☐ Hardwig House**	☐ BHH
☐ PSS*	☐ Medication Management	☐ Northern Opportunity Works (NOW)

Please explain the reason(s) you are seeking mental health services:

CURRENT LIFE SITUATION

Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Remarried ☐ Separated ☐ Widowed ☐ Living with significant other (boyfriend/girlfriend/fiancé)

Where do you live?	☐ Private Residence/Independent ☐ Private Residence/Dependent ☐ Board & Lodge ☐ Crisis Residency ☐ Foster Home ☐ Homeless ☐ Hospital ☐ Institution ☐ Residential Care ☐ Jail/Correctional Facility ☐ Nursing Facility/Boarding Care ☐ Regional Treatment Center ☐ Children's Residential Treatment Facility ☐ Other Residential Status
How long have you resided at your current location?	
Who do you reside with? ☐ Alone ☐ Spouse ☐ Parents ☐ Children ☐ Friends ☐ Other:	
Please tell us the name, age, and relationship of who you live with: (please use additional sheet of paper, if you need more room.)	

Name:	**Age:**	**Relationship:**

How would you describe your living situation? ☐ Excellent ☐ Good ☐ Okay ☐ Poor

INCOME/EMPLOYMENT INFORMATION

Current Source of Income: ☐ Wages ☐ Social Security ☐ Pension ☐ MFIP ☐ Child Support ☐ Other: _____________	
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Disabled ☐ Retired ☐ Homemaker ☐ Volunteer ☐ Unemployed ☐ Student	
Employers Name:	**Occupation:**

EDUCATIONAL HISTORY

Education:	☐ Highest Grade Completed: ____ ☐ College or Post Graduate; Degree: ____ ☐ Currently Enrolled; School Attending:
Special Education Services:	☐ No ☐ Yes, please tell us what services [for example, IEP, 504 Plan, Emotional Behavioral Disorder Services (EBD)]:____
Barriers to learning (reading/writing/math) or Past School Testing:	

EARLY CHILDHOOD HISTORY

Early Childhood/Childhood Development - Any concerns with development, nutrition, and social concerns?
Normal Birth: ☐ Yes ☐ No, list any complications or birth defects, etc.:
Were early childhood milestones met on time? ☐ Yes ☐ No, please explain:
List any special needs in childhood:

WOMEN

Are you currently pregnant? ☐ No ☐ Yes, due date:
Do you experience regular periods? ☐ Yes ☐ No, please explain:

DENTAL

Who is your current dental provider, if known?
When was your last dental visit (approximately)?

SUBSTANCE OR ALCOHOL HISTORY

Have you participated in a substance use treatment program?

☐ No ☐ Yes, please explain:

Agency: ____

Date: ____

Do you feel that you have a problem with alcohol and/or substances? ☐ No ☐ Yes
If yes, would you like help and/or a referral? ☐ No ☐ Yes
Any family history of substance or alcohol abuse/dependence? ☐ No ☐ Yes, please explain:
Please describe use of the following: (Check box if using; note how often) ☐ **Alcohol:** Uses _____ times per day/week; Amount per use______ ☐ **Tobacco/Vape:** Uses _____ times per day/week; Amount per use______ ☐ **Chewing Tobacco**; How Much_____________________ ☐ Smoke Type: ____ ☐ **Caffeine:** Uses _____ times per day/week; Amount per use _____ ☐ **Marijuana:** Uses _____ times per day/week; Amount per use _____ ☐ **Other (ecstasy, meth, inhalants, cocaine, etc.):** _________________Uses _____ times per day/week; Amount per use_____ ☐ **Non-medical use of prescribed or over-the-counter drugs (Vicodin, Percocet, Ritalin, etc.):** __________________________ Uses _____ times per day/week; Amount per use _____

MENTAL HEALTH HISTORY

Please let us know what symptoms you may be experiencing: ☐ Anxiety ☐ Depression ☐ Eating Disorder(s) ☐ Life Transitions ☐ Grief/Loss ☐ ADHD ☐ Trauma ☐ Family/Marital
Have you received a Diagnostic Assessment and/or Psychological Testing in the past year? ☐ No ☐ I do not know ☐ Yes, please explain: **Agency:** ____ **Date(s):** ____
Have you received Mental Health Service (Therapy) in the past year? ☐ No ☐ I do not know ☐ Yes, please explain: **Agency:** ____ **Date(s):** ____
Do you currently have a MH Case Manager: ☐ No ☐ Yes, name & agency:____
Have you seen a Psychiatrist or a Nurse Practitioner for medication management? ☐ No ☐ I do not know ☐ Yes, please explain: **Agency:** ____ **Date(s):** ____
Other:
Do you have a Psychiatric Health Care Directive: ☐ No ☐ Yes
Would you like more information on a Psychiatric Health Care Directive: ☐ No ☐ Yes

MEDICAL HISTORY

List significant current or past medical conditions:		
Have you had your thyroid checked? ☐ No ☐ Unsure ☐ Yes, approximate date:		
If yes, results: ☐ Normal ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Unknown		
Any family members with a thyroid condition? ☐ No ☐ Yes, who and what type, (if known):		
List your Primary Care Provider/Clinic:		
Most recent medical appointment date, (if known):		
Previous Surgeries (type and dates):		
Please list known allergies below (for example, seasonal, latex, medication allergies):		
Allergic To:	**Severity:**	**Reaction:**
Are you currently disabled? ☐ No ☐ Yes, please explain:		
Do you have a history of head trauma, concussions, seizures, stroke, or loss of consciousness? ☐ No ☐ Yes, please explain:		

Do you have pain which interferes with daily activities? ☐ No ☐ Yes, please explain:
Do you exercise? ☐ No ☐ Yes, please explain:
Have you gained/loss more than 10lbs in the past 6 months without trying? ☐ No ☐ Yes, please explain:
Do you eat regular meals? ☐ No ☐ Yes, please explain:
Significant medical problems of immediate family members and/or medical problems that run on your side of extended family?
Do you have a Health Care Directive? ☐ No ☐ Yes
W**ould you like more information on Health Care Directives?** ☐ No ☐ Yes

MEDICATION

Preferred Pharmacy:			
List current medications below with name and dosages, if known, or attach a list:			
Medication Name:	**Dose:**	**Medication Name:**	**Dose:**

Do you experience any medication side effects? ☐ No ☐ Yes, please explain:			
Medication Name:	**Reaction:**	**Medication Name:**	**Reaction:**

Are you currently utilizing any supplemental treatments (St. John's Wort, Herbs, Vitamins, etc.)? List name and dosages, if known, or attach a list:			
Supplemental Treatment Name:	**Dose:**	**Supplemental Treatment Name:**	**Dose:**

ADDITIONAL INFORMATION

Please list, to the best of your knowledge, any family members or people whom you have a significant relationship with that currently works for Northland Counseling Center, Inc. to avoid a conflict of interest for your provider.			
Name:	**Relationship:**	**Name:**	**Relationship:**

SIGNATURE

Signature:	**Date:**
If a guardian or power of attorney is indicated above, the guardian or power of attorney must sign all the paperwork.	

CLIENT REGISTRATION FORM

Client Name____ **Client Date of Birth**______________________________

RIGHTS AND RESPONSIBILITIES:

1. I have been informed of my rights and if I feel like I have been discriminated against because of race, religion, national origin, sex, gender identity or age I may complain to this agency, to the State or Federal agencies listed in the "Notice of Privacy Practices".
2. I have been informed regarding my rights; have been read the Tennessen Warning; have had my initial questions answered regarding these issues; and have been given the handouts "Client's Bill of Rights", "Notice of Privacy Practices", and "Grievance Procedures". I understand that I may request further information at any time. (If you are filling this out online you may print these forms at any time.)
3. I have been informed, and I understand that management personnel reserve the right to attend clinical staffing's where my case may be reviewed. This is to ensure that appropriate services are being offered and provided and ensure an effective interdisciplinary team approach.
4. By signing this form, I am giving "Consent for Treatment."

INSURANCE / INCOME:

If you currently have insurance, please fill out the following information if available and applicable:

Insurance Company:	
Insurance Company Address:	
Group #:	ID #:
Insurance Company Phone Number:	
Employer Name:	
Subscriber Name:	Policy Holder DOB:
Policy Holder Address:	
Relationship:	

If you have a secondary insurance please list below:

Insurance Company:	
Insurance Company Address:	
Group #:	ID #:
Insurance Company Phone Number:	
Employer Name:	
Subscriber Name:	Policy Holder DOB:
Policy Holder Address:	
Relationship:	

***If you have additional insurance please provide that information on the back of this form, thank you!**

☐ **Check here if you do not have insurance, and would like more information on filling out a sliding fee application.**

You can also contact any one of our office locations:

- Aitkin, Grand Rapids & Hibbing: 218-326-1274 and ask to speak with someone about the sliding fee application.
- International Falls: 218-283-3406 ext. 122 and ask to speak with someone about the sliding fee application.

☐ **Check here if you plan to use your employers' Employee Assistance Program (EAP).**

It is YOUR responsibility to contact your EAP provider AND provide the authorization number prior to your appointment. If the information is **NOT** received, you may be responsible for the payment of services.

☐ **Check here if you are between the ages of 16 – 17-years old and are consenting to *treatment without the consent of your parent/legal guardian and agree to assume **financial responsibility of your appointment(s).**

Treatment for the purposes of this document means outpatient services such as individual, group, family therapy, individual treatment planning, diagnostic assessments, medication management, and psychological testing.

****Financial responsibility*** means you agree to pay the fees associated with the services that you are provided. If your services are paid through insurance and the insurance policy is through your parents and/or legal guardians, Northland Counseling Center, Inc. is NOT responsible for any information sent to your parent/guardian through the insurance company (for example: explanation of benefits). If you cannot afford the fees associated with the services provided, please ask our staff about a sliding fee scale. ***By signing this form, you assume financial responsibility of your services.***

RELEASE OF INFORMATION:

By signing below, I authorize Northland Counseling Center, Inc. (NCC), to release information to my insurance company regarding my treatment here. This may include my social security number, diagnosis, prognosis, dates of treatment, narrative notes and types of treatment. I permit a facsimile or photographic reproduction of this authorization in place of the original. This is for the purpose of validating claims submitted to my insurance company. I also authorize my insurance to make payments to NCC for all insurance benefits to which I or my dependents are entitled for services received at NCC. I understand that my consent terminates one year from the date of signature, unless I choose to revoke it earlier. I affirm that the information reported above is accurate and that the fee, payment method, and release of information have been discussed. If my financial status changes, an update of this agreement may be renegotiated. This release includes any insurance that I may have at the time of my, or my dependent's, services.

PAYMENT PLAN:

By signing below, I agree to the following:

- Each month, I will pay a minimum of 25% of the total balance due until all charges are paid.
- Following each visit, I will pay the charges for that visit.
- Upon receipt of a monthly statement, I will remit the amount due.
- I will be responsible for payment for any services denied by my insurance company, including but not limited to deductibles, co-pays and exclusions.
- I understand that I am responsible for the charges in full, forfeiting my opportunity to be placed on the sliding fee scale, if I do not comply with the following (when applicable):
    - Provide verification of income documentation.
    - Obtaining a physician referral when my insurance requires one.
    - Applying for medical assistance and notifying Northland Counseling Center, Inc. (NCC) of disposition if referred.
- A fee may be charged for any missed appointments which are not canceled at least 24-hours in advance.
- I recognize that it is my responsibility to be aware of my insurance benefits and payment by insurance is not guaranteed.

In the event NCC has been unable to collect payment from me for services within a reasonable period of time, NCC then reserves the right to turn the account over to an attorney or collection agency (this may include: address; phone/cell phone number; email, etc.). I understand that interest, finance charges and other costs, as allowed by law, will be added to my account. A 15% processing fee will be added to any account sent to collections.

MISSING APPOINTMENT POLICY:

Attendance at your appointments is important to your care. All of our providers have waitlists for others seeking services. When you do not give at least a 24-hour notice, our staff are often unable to fill your time slot with someone on the waitlist. Therefore, please notify us as soon as you are able when you realize you cannot attend a scheduled appointment. In addition, late arrival to appointments can interfere with the therapeutic process. If you are more than 10 minutes late to your appointment, you may not be seen. Most importantly, you are not able to benefit from therapy and/or medication management if tardiness or absences become frequent.

By signing below, I agree to the following:

- I agree to provide a 24-hour notice if I am going to miss a scheduled appointment.
- I will not schedule an appointment at a time when I know I am not able to attend.
- I understand that TWO consecutive no-shows or TWO late cancelations will result in me forfeiting future appointment times.

HEALTH RECORD:

A health record location service helps my mental health providers determine where I have received care and obtain information about my health to help treat me. NCC may access my information in a record locator service to help provide care to me. NCC may share my health record and information with a record locator services unless I CHECK the box below. If I check the box below, I understand NCC will exclude my information in any record locator service.

☐ **I do <u>NOT</u> want my information shared in a record locator service for coordination of care reasons.**

TELEHEALTH CONSENT:

By signing below, I consent to the use of telehealth services for myself / child / dependent / person who I serve as their guardian of. You may obtain a copy of NCC's telehealth information by request.

CLIENT SIGNATURE: DATE:

RESPONSIBLE PARTY SIGNATURE:

NORTHLAND STAFF SIGNATURE: DATE:

Patient Health Questionnaire (PHQ-9)

Name: ____ Date: ____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use an "X" to indicate your answer)	**Not at All**	**Several Days**	**Over Half of the Days**	**Nearly Everyday**
Little Interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or over eating.	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
Staff Purpose Only: Add each column				
Staff Purpose Only: Total Score (*add your column scores*) =				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Please check the box next to the one that best describes the level of difficulty.

Not difficult at all: ☐ Somewhat difficult: ☐ Very difficult: ☐ Extremely difficult: ☐

Northland
Counseling Center, Inc

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Name: ____ **Date:** ______________________________________

Over the **last 2 weeks**, how often have you been bothered by the following problems? Please check the box:	**Not at All**	**Several Days**	**Over Half of the Days**	**Nearly Everyday**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worry.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worry too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happened.	☐ 0	☐ 1	☐ 2	☐ 3
Staff Purpose Only: Add each column				
Staff Purpose Only: Total Score (*add your column scores*) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Please check the box next to the one that best describes the level of difficulty.

Not difficult at all: ☐ Somewhat difficult: ☐ Very difficult: ☐ Extremely difficult: ☐

Name: ____

Date: ____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced **prior to your 18th birthday**. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.		
1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐ Yes	☐ No
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐ Yes	☐ No
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐ Yes	☐ No
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐ Yes	☐ No
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐ Yes	☐ No
6. Did you live with anyone who went to jail or prison?	☐ Yes	☐ No
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐ Yes	☐ No
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐ Yes	☐ No
9. Did you feel that no one in your family loved you or thought you were special?	☐ Yes	☐ No
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐ Yes	☐ No
I **decline** to provide the following information, please do not check above boxes.	☐ Yes	
Your ACE score is the total number of checked <u>YES</u> responses		

Do you believe these experiences have affected your health?	☐ **Not Much**	☐ **Some**	☐ **A lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Northland
Counseling Center, Inc

CAGE-AID

Name: ____ **Date:** ____

1. Have you ever felt you ought to cut down on your drinking or drug use?	☐ Yes (1)	☐ No (0)
2. Have people annoyed you by criticizing your drinking or drug use?	☐ Yes (1)	☐ No (0)
3. Have you felt bad or guilty about your drinking or drug use?	☐ Yes (1)	☐ No (0)
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐ Yes (1)	☐ No (0)
Staff Purpose Only: Total Score (*add your column scores*) =		

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (Print): ____ **Date of Birth:** ______________________________

I, ____authorize
(Client or responsible person)

Northland Counseling Center, Inc. and/or Northland Recovery Center to:
☐ **Exchange Information With** ☐ **Give Information To** ☐ **Receive Information From**

***Name/Organization:** ____
Contact Person: ____
Address: ____City: _______________________ State: ______ Zip: ______________
Phone: ____ Fax: ____
Name/Organization MUST be filled out

For the following purpose(s):		
☐ Coordination of Care	☐ Referral/Reference	☐ Legal/Court
☐ Disability Claims	☐ Emergency Contact	☐ Collateral
☐ Family Participation	☐ Network and Coordination of Housing Services	☐ Obtain Driver's License
☐ Financial	☐ Other: ______________________________________	

Approximate date(s) of information to be released/received (if applicable): _________________________**to** __________________________
3 years prior **1 year ahead**

Information to be disclosed (at least one box must be check):		
☐ Any/All Information	☐ Scheduling/Confirmation of Attendance	☐ Verification of SMI Diagnosis for Housing Application
☐ Treatment Summary	☐ Inpatient/Discharge Summary	☐ Diagnostic Assessment/Psychological Evaluation/Other Assessments
☐ Physician/Medical Health Records	☐ School/Educational Information	☐ Coordination for Housing and Housing Supports
☐ Labs	☐ Court Order/Legal Documents	☐ Billing, Insurance, and/or Financial Information
☐ Medication Regimen Records	☐ Verbal Information	☐ Other (specify): ________________________

I understand that I have the right to receive a copy of the release and that I may revoke this release at any time prior to the expiration date. This Release of Information is valid for one year from the date of signature unless otherwise indicated. The revocation will not apply to information that has already been disclosed in response to this release. A copy of this release is considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

I understand that records disclosed may include information related to the following: treatment for alcohol and drug abuse, mental health services, and/or HIV/AIDS status and I specifically authorize the release of this information. I understand that authorizing the disclosure of this information is voluntary and I have the right to refuse to sign this release. I further understand that refusing to sign this release may or may not affect the assurance of treatment, payment, enrollment, or eligibility for benefits.

I understand that Northland Counseling Center and/or Northland Recovery Center cannot disclose information to anyone other than listed above and that information used or disclosed pursuant to this release is protected under federal confidentiality rules (42 CFR Part 2). A general release of information is not sufficient for the release of these records. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

In accordance with 42 CFR Part 2, this information may not be redisclosed by the recipient unless redisclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. I understand that, although redisclosure of information is prohibited, there is a potential that the information may be redisclosed by the recipient without my permission and no longer protected under the federal confidentiality rules.

____
Client/Guardian Signature **Date**

____
Witness Signature **Date**

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ____________________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (Print): ____ **Date of Birth:** _____________________________

I, ____authorize
(Client or responsible person)

Northland Counseling Center, Inc. and/or Northland Recovery Center to:
☐ **Exchange Information With** ☐ **Give Information To** ☐ **Receive Information From**

***Name/Organization:** ____
Contact Person: ____
Address: ____City: ______________________ State: ______ Zip: ______________
Phone: ____ Fax: ____
Name/Organization MUST be filled out

For the following purpose(s):		
☐ Coordination of Care	☐ Referral/Reference	☐ Legal/Court
☐ Disability Claims	☐ Emergency Contact	☐ Collateral
☐ Family Participation	☐ Network and Coordination of Housing Services	☐ Obtain Driver's License
☐ Financial	☐ Other: ____	

Approximate date(s) of information to be released/received (if applicable): ________________________to __________________________
3 years prior **1 year ahead**

Information to be disclosed (at least one box must be check):		
☐ Any/All Information	☐ Scheduling/Confirmation of Attendance	☐ Verification of SMI Diagnosis for Housing Application
☐ Treatment Summary	☐ Inpatient/Discharge Summary	☐ Diagnostic Assessment/Psychological Evaluation/Other Assessments
☐ Physician/Medical Health Records	☐ School/Educational Information	☐ Coordination for Housing and Housing Supports
☐ Labs	☐ Court Order/Legal Documents	☐ Billing, Insurance, and/or Financial Information
☐ Medication Regimen Records	☐ Verbal Information	☐ Other (specify): _______________________

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____
Client/Guardian Signature **Date**

____
Witness Signature **Date**

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ____________________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (Print): ____ **Date of Birth:** ______________________

I, ____ authorize
(Client or responsible person)

Northland Counseling Center, Inc. and/or Northland Recovery Center to:

☐ **Exchange Information With** ☐ **Give Information To** ☐ **Receive Information From**

***Name/Organization:** ____
Contact Person: ____
Address: ______________________ City: ______________ State: ______ Zip: __________
Phone: ______________________ Fax: ______________________
Name/Organization MUST be filled out

For the following purpose(s) (at least one box must be check):		
☐ Coordination of Care	☐ Referral/Reference	☐ Legal/Court
☐ Disability Claims	☐ Emergency Contact	☐ Collateral
☐ Family Participation	☐ Network and Coordination of Housing Services	☐ Obtain Driver's License
☐ Financial	☐ Other: ______________________	

Approximate date(s) of information to be released/received (if applicable): ______________ **to** ______________
3 years prior **1 year ahead**

Information to be disclosed (at least one box must be check):		
☐ Any/All Information	☐ Scheduling/Confirmation of Attendance	☐ Verification of SMI Diagnosis for Housing Application
☐ Treatment Summary	☐ Inpatient/Discharge Summary	☐ Diagnostic Assessment/Psychological Evaluation/Other Assessments
☐ Physician/Medical Health Records	☐ School/Educational Information	☐ Coordination for Housing and Housing Supports
☐ Labs	☐ Court Order/Legal Documents	☐ Billing, Insurance, and/or Financial Information
☐ Medication Regimen Records	☐ Verbal Information	☐ Other (specify): ______________

I understand that I have the right to receive a copy of the release and that I may revoke this release at any time prior to the expiration date. This Release of Information is valid for one year from the date of signature unless otherwise indicated. The revocation will not apply to information that has already been disclosed in response to this release. A copy of this release is considered as valid as the original. A fee may be required for the retrieval and photocopying of records.

I understand that records disclosed may include information related to the following: treatment for alcohol and drug abuse, mental health services, and/or HIV/AIDS status and I specifically authorize the release of this information. I understand that authorizing the disclosure of this information is voluntary and I have the right to refuse to sign this release. I further understand that refusing to sign this release may or may not affect the assurance of treatment, payment, enrollment, or eligibility for benefits.

I understand that Northland Counseling Center and/or Northland Recovery Center cannot disclose information to anyone other than listed above and that information used or disclosed pursuant to this release is protected under federal confidentiality rules (42 CFR Part 2). A general release of information is not sufficient for the release of these records. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

In accordance with 42 CFR Part 2, this information may not be redisclosed by the recipient unless redisclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. I understand that, although redisclosure of information is prohibited, there is a potential that the information may be redisclosed by the recipient without my permission and no longer protected under the federal confidentiality rules.

____
Client/Guardian Signature **Date**

____
Witness Signature **Date**

If signing as the Authorized Representative to the client, I am: (please check one)
☐ Court Appointed Guardian
☐ Custodial Parent of minor child
☐ Other: ______________