FORMS NEEDED FOR
ADULT ANNUAL UPDATE PACKET

When do Adult client's complete the Annual Update Packet?

- When they are currently receiving services within NCC and their annual paperwork is due.
- When they have received a service(s) in past 364 days and the annual paperwork is due.

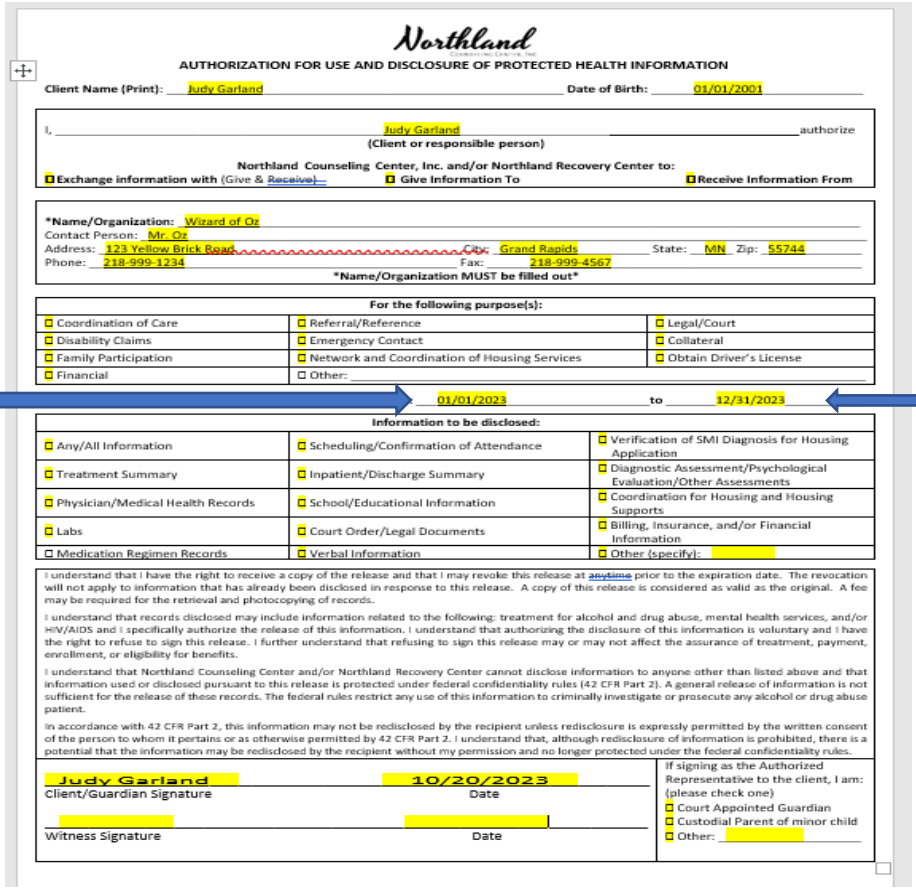
When does an Adult do a NEW packet?

- When they are new to the agency.
- When it has been longer then 365 days since their last service with NCC.

Please fill out the following forms:

- Adult ANNUAL Update
- Client Registration form (NOTE: If a client enters a program -NOW, Crisis, Housing – please complete this form)
- PHQ-9
- CAGE-AID
- GAD-7
- ACES
- Provider Supervision form
- Release of Information
    - Primary Health Clinic(s)
    - Mental Health Agency (in the past year)
    - Medication Management Agency (In past 3 years)
        - You do NOT need to fill out a Release of information for Northland Counseling Center, Inc.

ROI example below:



Northland

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client Name (Print): Judy Garland Date of Birth: 01/01/2001

I, Judy Garland authorize
(Client or responsible person)

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

☐ Exchange information with (Give & ~~Receive~~) ☐ Give Information To ☐ Receive Information From

*Name/Organization: Wizard of Oz
Contact Person: Mr. Oz
Address: 123 Yellow Brick Road City: Grand Rapids State: MN Zip: 55744
Phone: 218-999-1234 Fax: 218-999-4567
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:	

Date can go back 3 years

01/01/2023 to 12/31/2023

Date goes ahead one year

Information to be disclosed:		
☐ 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 ~~anytime~~ prior to the expiration date. 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 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.

Judy Garland 10/20/2023
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:

NORTHLAND COUNSELING CENTER, INC.

ADULT ANNUAL UPDATE

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:**			

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:**
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.	

CURRENT LIFE SITUATION

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

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

EDUCATIONAL HISTORY

Education:	☐ Highest Grade Completed: _____ ☐ College or Post Graduate, Degree: _____ ☐ Currently Enrolled, School Attending:

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

WOMEN

Are you currently pregnant: ☐ No ☐ Yes, Due Date:
Do you experience regular periods: ☐ Yes ☐ No, please explain:

MENTAL HEALTH HISTORY

If you have any of the following services and/or providers, please indicate:
Mental Health Therapist:
Medication Manager:
Case Manager:
Other:
Other:
Do you have a Psychiatric Health Care Directive: ☐ No ☐ Yes
If no, would you like more information on Psychiatric Health Care Directive: ☐ No ☐ Yes

MEDICAL HISTORY

List significant current or past medical conditions:		
List your Primary Care Provider/Clinic:		
Most recent medical appointment date, *(if known)*:		
Please list known allergies below, for example; seasonal, latex, medication allergies:		
Allergic To:	**Severity:**	**Reaction:**
Do you have a Health Care Directive: ☐ No ☐ Yes		
If no, would you like more information on Health Care Directive: ☐ 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:	**Reaction:**	**Medication:**	**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:**

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 120 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. You may obtain a copy of NCC's telehealth information by request.

CLIENT SIGNATURE: DATE:

RESPONSIBLE PARTY SIGNATURE:

NORTHLAND STAFF SIGNATURE: DATE:

Northland
COUNSELING CENTER, INC

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: ☐

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)
<u>Staff Purpose Only:</u> Total Score =		

Name: _____

Date: _____

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

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, and did not check any of the above boxes.	☐ DECLINE	
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

Supervision Waiver

CLIENT NAME: _____ **DOB:** _____

Dear Client,

Northland Counseling Center, Inc. is Licensed by the MN Department of Health & Human Services. We employ a multidisciplinary mental health team with a broad spectrum of training and experience. Credentials for all of our staff are available at the front desk or online.

As part of our multidisciplinary team approach, we employ mental health professionals, mental health clinical trainees, interns and practicum students. All of the staff participate in consultation with the team and their individual clinical supervisors. Some of our mental health staff are credentialed by certain health plans and not by others. One of the following may apply to the provider you will be working with:

- **Doctoral Intern, supervised by a Mental Health Professional.**
- **Clinical Trainee, supervised by a Mental Health Professional.**
- **Licensed Mental Health Professional, NOT credentialed by your health plan AND supervised by a credentialed provider.**
- **Practicum Student, supervised by a Mental Health Professional.**
- **Internship Student, supervised by a Mental Health Professional**.

One of the following credentialed providers will be supervising your services:

- Angie Baratto, MA, LPCC
- Danielle Krasaway, MS, LPCC
- Jennifer Alstad, MS, Ed., LMFT
- Kerrie Humble, MSW, LICSW
- Amy Schaffer, MA, LP
- Amie Madl, MA, LMFT, RPT-S
- Laura Maxwell, MSW, LICSW
- Brandi Worrath, MS, LPCC
- Sara Sundquist-Castle, MPS, LADC, LPCC
- ☐ Other_____
- Dessa Bergan, MSW, LICSW
- Brea Wallaker, MSW, LICSW
- Allison O'Hara Meyers, Psy.D., LP
- Miranda Skinner, MPS, LADC, LPCC

I have read and understand the information and agree to services as indicated.

_____ _____

Client and/or Parent/Guardian Signature **Date**

Northland
COUNSELING CENTER, INC

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 <u>one</u> 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 <u>one</u> 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.

"Northland Counseling Center" is a general designation that refers to any substance use or mental health program operated by Northland Counseling Center, Inc.

_____
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: _____

Northland
COUNSELING CENTER, INC

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 <u>one</u> 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 <u>one</u> 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.

"Northland Counseling Center" is a general designation that refers to any substance use or mental health program operated by Northland Counseling Center, Inc.

_____
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: _____

Northland
COUNSELING CENTER, INC

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 <u>one</u> 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 <u>one</u> 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.

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Client/Guardian Signature **Date**

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