Northeastern
MENTAL HEALTH CENTER

14 South Main Street, Suite 1E | Aberdeen, SD 57401
(605) 225-1010 | **www.nemhc.org**

_____ **Request Records** _____ **Send Records** _____ **File Release**

Authorization for Disclosure of Health Information

First Name: _____ Middle Initial: _____ Last Name: _____

Birthdate: _____

I hereby request and authorize:

Name of Facility/Person: _____

Address: _____

To release information from the above client's health record to:

Name of Facility/Person: _____

Address: _____

The purpose/need for such exchange is:

_____ Service Provision _____ Legal _____ Health Home Coordination _____ Personal

_____ Referral for Service _____ Insurance _____ Service Coordination _____ Other_____

Specific Information to be exchanged:

_____ Treatment Plans _____ Treatment Summaries/Discharges _____ Other _____

_____ Assessments/Evaluations _____ Summary of Treatment Contacts

All records pertaining to drug or alcohol abuse will not be released unless specifically authorized below. *I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.*

_____ Drug or Alcohol Abuse

_____ _____

Signature *Date*

This authorization shall remain in effect until the following date, event or condition: _____

If no date, event or condition is specified, this authorization will expire in 1 year after last contact with NEMHC.

- I understand I have the right to revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing.
- I understand a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
- I need not sign this authorization to assure treatment.
- I understand that I may inspect or receive copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
- I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be disclosed and no longer by protected by these federal regulations.
- If I have any questions about disclosure of my health information I can contact NEMHC Medical Records at (605)-225-1010.

_____ _____

Authorized Signature *Date*

Relation (if not client): _____

_____ _____

NEMHC Staff Signature *Date*

01/04/2017