Authorization to Disclose Information
Confidential

Patient Name: (please print): ____________________ **Birthdate:** __________

Other names used in treatment, if any: ____________________

I authorize Hazelden to disclose information about me to:

Name: ____________________ Attention: __________

Address: ____________________ Phone: __________

City, State, Zip: ____________________ Fax: __________

Relationship to Patient: ____________________

Check all types of information to be disclosed to above party:

_____ To verify treatment:

☐ Treatment dates ☐ Discharge status

_____ Medical history

_____ Physical Exam

_____ Lab Test Results

_____ Doctor's Notes

_____ Chemical Dependency assessment

_____ Psychologist assessment Other:____________________

_____ Psychiatrist assessment

_____ Discharge Summary

_____ Continuing Care

☐ Attendance ☐ Continuing Care Plan

_____ Follow Up:

☐ To locate me ☐ Progress Updates

_____ Other: (Specify) ____________________

Information and records requested may include reference to my HIV/AIDS status:

☐ I do want this included ☐ I do not want this included or it is NOT APPLICABLE

Why the information is needed: ☐ Legal (specify case type) ____________________

☐ Benefits/insurance related

☐ Other ____________________

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 Hazelden's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. Hazelden's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- 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 Hazelden.
- Federal confidentiality regulations (42 CFR Part 2) prohibit redisclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Hazelden to notify me of the potential that information disclosed pursuant to this authorization might be redisclosed by the recipient and is no longer protected by the HIPAA rules.
- This authorization may be used by Hazelden owned or managed programs upon transfer of my care to them.

Client Signature: ____________________ **Date:** __________

Parent/Guardian Signature:
(when required) ____________________ **Date:** __________

***** Please send form to Hazelden, 15251 Pleasant Valley Rd. PO Box 11, BC22, Center City, MN 55012-0011*****