MHS
6600 France Ave. S., Suite 230
Edina, MN 55435
P: 952-835-2002
F: 651-383-4935

Release of Information

Client Name: **DOB:** **Date:**

I, (DOB)**:** **, authorize Mental Health Systems, INC to:**

Information With: **Name:**

☐ County Case Manager
☐ Psychologist
☐ Psychiatrist
☐ Physician/Clinic
☐ Neuropsychologist
☐ Day Program
☐ Family
☐ Guardian/Conservator
☐ Other:
☐ Other:

The following information to be :

☐ Discharge Summary
☐ History and Physical
☐ Consults
☐ Neuropsychological/Psychological testing
☐ Diagnosis
☐ Chemical Health Information
☐ Case Plan/Notes
☐ Medications/Dosage
☐ Other

Purpose for disclosure:

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items to can occur:

☐ Verbally ☐ In person conference ☐ Written questionnaire ☐ Mailed or faxed medical record / correspondence

I understand that:

* My health information is protected by federal regulation (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 Mental Health Systems, INC'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. Mental Health Systems, INC's Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign or unless I request an earlier expiration in writing.
* For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)
* Communications resulting from this authorization will reveal that I receive services at Mental Health Systems, INC.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Mental Health Systems, INC to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
* This authorization may be used by Mental Health Systems, INC owned or managed programs upon transfer of my care to them.

Patient Signature _____ **Date:** _____

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Parent or Guardian Signature _____ **Date:** _____

Staff Signature _____ **Date:** _____

**** Information to be disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from 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.**