# AUTHORIZATION FOR RELEASE OF INFORMATION

C O R E S P

Name of Patient _____ Birthdate _____

I hereby authorize Archway Mental Health Services PO Box 5510 Bismarck ND 58506-5510
(Name and Address of Individual or Organization)

to release to _____
(Name and Address of Individual or Organization to Receive Information)

the following information from my medical record from the beginning of treatment at AMHS to one year past date of this release unless otherwise indicated: _____.

____ Clinic visits Progress Notes ____ Initial Evaluation ____ Lab/EKG/EEG/Radiology

____ Two-way Written ____ Two-way Verbal ____ Educational Reports

____ Neuropsychological Evaluation ____ Psychological Evaluation

____ Specify Other _____

**ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.**

I specifically authorize the release of the following records:

❑ Psychiatric/Psychological _____ Initials ❑ HIV _____ Initials ❑ Drug And/or Alcohol Dependency _____ Initials

The information is necessary for the following purpose:

____ Diagnosis and Treatment ____ Legal ____ Application for Insurance ____ Personal

____ Disability Determination ____ Vocational Rehabilitation Evaluation ____ Other

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 one year.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. 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 in order to assure treatment.
3. I understand that I may inspect or request 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.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

_____ _____ _____
(Signature of Patient or Legal Representative) (Relationship) (Date)

_____
(If patient unable to sign, state reason.)

_____ _____ _____
Signature Witness Provider Signature Provider Signature

❑ **CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS**

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.