CROW WING COUNTY MINNESOTA

Authorization for Disclosure of Information

CWC-1040
06-24

***Note*: All applicable items on this form should be completed to ensure prompt release of information.**

Client Information	**Client Name:**		**Date of Birth:**
	Previous Name(s):		**Phone #:**
	Address:	**Email Address:** (optional)	
	City:	**State:**	**Zip Code:**
Reason for Disclosure	☐ Coordination of Care ☐ Client Request/Personal ☐ Legal/Court ☐ Insurance Company ☐ Financial/Billing ☐ Family Request ☐ Other (please specify):		
How do you want the information released	☒ Exchange with (paper and/or verbal) ☐ Fax (for patient care only) ☐ Email (email required below) ☐ Pickup (photo ID required @ pickup) ☐ Mail (address required below) ☐ Verbal Only (NO actual records given)		
Release/Receive Information From Crow Wing County Community Services (CWC CS)	☐ Comm. Services ☐ Substance Abuse ☐ Child Protection ☐ Attorney's Office ☐ Community Corrections ☐ Jail ☐ Child Support		
	Business Name:		**Phone #:**
	Contact Name:		**Fax #:**
	Address:	**Email:**	
	City:	**State:**	**Zip Code:**
Recipient **To do the following:** ☐ Release info to ☐ Receive info from	**Business Name:**		**Phone #:**
	Contact Name:		**Fax #:**
	Address:	**Email:** email	
	City:	**State:**	**Zip Code:**

Information to be Released (Disclosed) If dates are not specified, only the most recent visit will be released.	**Please Specify Dates of Service**		**From Date:**	**To Date:**
	☐ Progress Notes	☐ Diagnostic Assessment (DA)	☐ Psychological Evaluation	☐ School Records
	☐ Verbal Only (NO Records)	☐ Medication Notes	☐ Psychiatric Evaluation	☐ Legal/Court/PO
	☐ Treatment Plans	☐ Billing Records	☐ Summary of Services	☐ Social Services Info
	☐ Other (please specify):			

Special Consents If dates are not specified, only the most recent visit will be released. **Prohibition on Re-Disclosure** (42 CFR, Part 2)	**This section for Chemical Dependency Records only.** **The law requires a Special Consent for Chemical Dependency Program Information.**		
	Please Specify Dates of Service	**From Date:**	**To Date:**
	☐ CD Assessment Summary ☐ CD Weekly Summary Notes ☐ CD Discharge Summary ☐ Rule 25 ☐ Verbal Only (NO records) ☐ Other (please specify):		
	Each disclosure made with the client's written consent must be accompanied by the following written statement: This information has been 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.		

Re-Disclosure	**CWC CS cannot prevent the re-disclosure of records released as a result of this request, and after the information is released from CWC CS, the records may not be subject to the Federal Privacy Rule Laws.** A photo copy of this authorization will be treated in the same manner as the original.	
Expiration	**This consent will expire one year from the date the form is signed** unless I indicate a different expiration date or event.	
	Date:	**Specific Event:** (can shorten or lengthen the expiration period)
Revocation	**I have the right to revoke this authorization at any time by giving written notice to the CWC Community Services Department.** I understand that the revocation will not apply: 1) to information that has already been released in response to this authorization, or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.	
Authorization	**Client, or Parent, or Guardian Signature:** (typing a name into this field is equivalent to an actual signature)	**Date:**
	Reason Client is unable to sign: ☐ Minor ☐ Legal (documentation req'd) ☐ Client is not own Guardian (documentation req'd) ☐ Other (please specify):	

Please return to Crow Wing County Community Services | 204 Laurel St., Brainerd, MN 56401
Telephone 218-824-1140 | Fax 218-824-1305 | Email cwcss@crowwing.gov