



Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Case # \_\_\_\_\_

I authorize Woodland Centers: to \_\_\_\_\_ Exchange with OR \_\_\_\_\_ Disclose to OR \_\_\_\_\_ Obtain from

Name of Organization or Individual: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

**Reason for Release:**

- Coordination of Care
- Client's Request\*
- Insurance \*
- Legal\*
- Other \_\_\_\_\_

\*Fees may be charged in accordance with Minn. Statute §144.292 and Federal Rule 45 CFR 164.542

**Records from the Following Dates:**  All (Including Past, Present, Future)  Specific date(s) \_\_\_\_\_ to \_\_\_\_\_

**Information to be Released (please mark appropriate boxes):**

Any/All Records (may include sensitive information such as drug and/or alcohol records)

**OR** to only release specific portions of your health information, indicate the categories to be released:

- Summary of Services (Includes Discharge Summary, History/Physical, Consultations, and Test Results)
- Mental Health Evaluations (Including Psychological Testing)
- Progress Notes/Office Visits
- Medication list
- Lab/Radiology Reports
- Legal/ Court Records
- School Records (IEP reports)
- Social Service records
- Substance Use Treatment Records
- Discharge Summary
- Other (Specify Content): \_\_\_\_\_

**I UNDERSTAND THE FOLLOWING:** I have had full opportunity to read and consider this Authorization to Release Information and the contents are consistent with my direction to Woodland Centers to release nonpublic personal health information.

- **Alcohol/Drug Abuse Treatment Records:** Treatment records for alcohol or drug abuse may be included if indicated above. If this release involves the disclosure of information concerning alcohol or drug abuse treatment, this information has been disclosed from records protected by federal confidentiality rule, 42 CFR, part 2. Federal law prohibits a recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains or as otherwise permitted by 42 CFR, Part 2.
- **Authorization Period:** The release of records includes both past and future records until the authorization expires or is revoked, unless a specific date range is mentioned.
- **Right to Revoke:** I can revoke this authorization at any time with written notice, but any revocation will not apply to records already released.
- **Voluntary Authorization:** Signing this authorization is not required in order to receive services unless the services are court-ordered by a third party.
- **Redisclosure disclaimer:** Woodland Centers cannot prevent the redisclosure of release records, and once released, the records may no longer be protected by federal or state privacy laws.
- **Two-Way Communication:** The authorization allows for two-way telephone communication and electronic transmission of information.
- **Right to Copy:** I am entitled to a copy of the authorization after signing and can request copies of disclosed information
- **Photocopy/Facsimile Validity:** A photocopy or fax of the authorization is as valid as the original.

This authorization shall remain in effect until the following date: \_\_\_\_\_ (If no date is indicated, the authorization expires one year from the date signed unless otherwise permitted by law.)

Client Signature	Date	Witness Signature	Date
(Required for clients age 16+ unless exception exists under law)			

Parent/Legal Guardian Signature	Relationship to Client	Date
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RETURN FORM/RECORDS TO: Woodland Centers HIMIS  
 1125 Se 6<sup>th</sup> St  
 PO Box 787  
 Willmar, MN 56201

Phone: 320-231-9156  
 FAX: 855-625-7406  
 Email: himis@wcenters.org

For office use only: Entered by: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Directions for Completion of Form. PLEASE COMPLETE ALL AREAS OF THE AUTHORIZATION TO ENSURE PROPER AND TIMELY DISCLOSURE OR RELEASE OF YOUR HEALTH INFORMATION.**

**Patient Information:** Please indicate the name of the client whose records are to be released, including date of birth. (Woodland Centers' staff will enter the Client ID number)

**“Exchange”, “Disclose”, or “Obtain”:** If you indicate “Disclose to”, Woodland Centers will not be able to receive any records from the organization and if you choose “obtain from” Woodland Centers will not be able to release information to this particular organization. Choosing “Exchange with” will allow Woodland Centers to disclose AND obtain records.

**Reason for Release:** Please indicate the reason records are to be released. This helps establish priority of the status of the release. It also helps determine who is responsible for the cost of records (when appropriate).

**Records from the following date:** Please choose “All” or specify a date or date range of records you would like released.

**Information to be released:** You may choose which records you want sent to include any and all records or pick specific information within your records to be released. If you chose Any/All records, Woodland Centers will be able to send any information from your record including all programs.

**I Understand:** This section explains the terms of the Authorization you are signing. Please read these terms carefully before signing this form.

**Expiration Date:** In this section you will decide when you would like the release to expire. ***If you do not indicate a date, the authorization will automatically expire one year from the date it was signed.*** If you wish to edit or revoke this form before the expiration date, please contact Health Information Management Services or the Privacy Officer.

**Signature:** Please sign AND date this form to validate this authorization. If this form is signed by someone other than the patient or parent, you will be required to provide proof of your authority (i.e. court order). A witness signature indicates who explained to the client or parent/legal guardian and/or helped complete the form.

***PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING OF THE RELEASE OF INFORMATION. IN SOME CASES, IT CAN TAKE UP TO 30 DAYS (45 CFR 164.524 (b)(2)(I)).***

**For questions or concerns regarding this form please contact the Health Information Management office at (320) 231-9156.**

**Completed Authorization to Release Protected Health Information may be sent to:**

**Health Information Management Services (HIMS)  
Woodland Centers  
PO Box 787  
Willmar, MN 56201**

**Or**

**FAX: (855) 625-7406**