SOUTH CENTRAL HUMAN RELATIONS CENTER
Providing Direction for Life's Problems Since 1964

Ph: 507-451-2630 Fax: 507-455-8133
610 Florence Avenue
Owatonna MN 55060

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Use this form if the Client requests ongoing release OR if request is from someone other than the client or their legal representative

Client Name: _____ **D.O.B.:** ___/___/___ **Client #:** _____

*I authorize South Central Human Relations Center to **send** ☐ **request** ☐ the private data specified below to/from:*
(A fee may be charged)

Name/Entity/Category: _____

Address _____ City _____ State _____ Zip_____

Email: _____ Encrypted: ☐ I understand the risk and request unencrypted: ☐

Fax: _____ HIE/PHR: _____

Information to be Released: Ongoing ☐ or Date from _____ to _____ or specific visit date: _____

___ Diagnostic Assessment ___ Psychiatric Evaluation ___ Testing results
___ Progress Notes ___ Verbal information ___ Psychological Reports
___ Letter(s) ___ Other (specify)_____

You must specifically request the following in order for it to be released:
___ Chemical Dependency Program
___ Psychotherapy Notes (conversational analysis) No other items can be checked when requesting this item

Reason: ___ Assessment and Treatment Planning ___ Continuity of Care
___ Other (specify, e.g. legal, appeal SS Disability, marketing) _____

Valid for: **One year ☐ or for this specified period**: _____

This authorization **does** ☐ **does not** ☐ extend to information placed in my record after the date I sign this form.

- *I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.*
- *I understand that I have the right to revoke this authorization. If South Central Human Relations Center has already released information based on this consent, we cannot retrieve what has already been released.*
- *I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and SCHRC can no longer protect it.*
- *I understand that I may refuse to sign this consent, if I so desire, and that SCHRC may not refuse treatment if I do not sign, but refusal may have consequences that have been explained to me.*

Signature:

_____ _____
Indicate if you are: Client, Parent, or Personal Representative (Provide legal proof if representative not parent) Date

_____
Type of identity verification

I **revoke** this authorization: _____ ___/___/___
Signed Date