OPTIONS Family & Behavior Services

(A Division of Community Drug & Alcohol Services, Inc.)

www.optionsfamily.com

2675 Long Lake Rd; Suite 125
Roseville, MN 55113
Phone: 651-209-6632
Fax: 651-209-8872

151 West Burnsville Pkwy; Suite 100
Burnsville, MN 55337
Phone: 952-564-3000
Fax: 651-925-0256

Release of Information

Client name: _____ Date of Birth: _____

I authorize OPTIONS Family & Behavior Services and Community Drug & Alcohol Services to:

_____ ☐ Receive information from:
_____ ☐ Release information to:
_____ ☐ Release and receive information to/from: Name/Credentials: _____

Agency: _____ Relationship: _____

Address: _____ Phone: _____ Cell _____

City, State, Zip: _____ Fax: _____

Work _____

Check and **initial** all types of information that may be released and/or obtained to/from above party:

_____ ☐ Treatment/Discharge Summary
_____ ☐ Chemical Dependency/Mental Health Assessment
_____ ☐ Progress Reports and Continuing Care
_____ ☐ Psychological Testing/Evaluation
_____ ☐ Psychiatric Consultation
_____ ☐ Verbal (In-person or phone conversation)
_____ ☐ School Reports/Records
_____ ☐ Social History
_____ ☐ Family History
_____ ☐ Legal History
_____ ☐ Medical history
_____ ☐ Laboratory Reports
_____ ☐ Physical Examination & Doctor notes
_____ ☐ Other: _____

This release is limited as follows: _____

This information is to be disclosed for the following purpose:

Treatment Planning, Coordination of Services, and Continuity of Care

- My health information is protected by federal regulations (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 OPTIONS Family & Behavior Services 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 of federal laws.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. OPTIONS Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)].
- Communications resulting from this authorization will reveal that I received services at OPTIONS Family & Behavior Services.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires OPTIONS 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 the HIPAA rules.

_____
Today's Date

_____
Signature of Client

_____
Signature of Parent/Guardian (if applicable)

_____
Signature of Staff

_____
Signature of Parent/Guardian (if applicable)