PRAIRIE ST. JOHN'S™

Authorization for Exchange of Information

____
Name of Patient

______________ ________________________
DOB Medical Record Number

U

____
Maiden/Other Names

RM.204.F03

I,____, **authorize** Prairie St. John's **510 4th Street South, Fargo, ND 58103 / 2925 20th St South, Moorhead, MN 56560** to Exchange confidential information with:

____
(Name and Organization)

______________________ ______________________ ______________ ______________
(Street Address) (City, State, Zip Code) (Telephone) (Fax #)

Information may be communicated: (Indicate Y/N) _______Written _______Faxed _______Verbal

Treatment from ____Current Admission *OR* ___________ (Date) to ___________ (Date) *OR* ___ Entire Medical Record History

(if no specific treatment dates are marked, records will be sent from most recent stay)

AT THE REQUEST OF THE INDIVIDUAL THE FOLLOWING INFORMATION IS TO BE EXCHANGED:

Indicate Y/N	Document Exchange	Date Sent	Sent by Initials		Indicate Y/N	Verbal Exchange	Date Exchanged	Initials
	Psychiatric Assessment					Treatment Plans		
	Discharge Summary					Progress in Treatment		
	Discharge Plans:					Acknowledgement of Service		
	History & Physical							
	Medical Consults							
	Psychological Consults/Testing							
	CD Evaluation							
	Lab Results							
	Other: (Must Specify) ____________							

THIS INFORMATION NECESSARY FOR: (CHECK ALL THAT APPLY)

☐Assessment, Treatment ☐Education Purposes ☐Insurance Purposes ☐Coordination and Follow up
☐Psychological Evaluation/testing ☐Discharge Planning ☐Acknowledge Referral ☐Legal Purposes
☐Other (must specify)______________________________

I understand that I may revoke this authorization at anytime except to the extent that action has been taken in reliance on it. Refer to the Privacy Notice for instructions regarding how to revoke authorizations or to inspect or receive copies of this information. I understand that this authorization will expire on: ___________ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.
I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization and my treatment and payment for treatment is not conditioned upon its completion. I further acknowledge that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by Federal confidentiality rules. Chemical Dependency records are further protected by a more stringent Federal Law (42 CFR Part 2) This information cannot be disclosed without the expressed authorization of the patient nor can the information be re-disclosed unless specifically authorized by the patient or as otherwise permitted by 42 CFR Part 2.
By signing below, I am authorizing the release of information pertaining to any chemical dependency (drug and/or alcohol) information. Minors 14 years and older must authorize release of drug and/or alcohol related services.

A photocopy or fax of this authorization will be treated in the same manner as the original.

______________________________ __________ ______________________________ __________
Signature of Patient (14 and older) Date Signature of Witness Date

______________________________ __________
Signature of Parent / Guardian (description of authority) Date

Please complete highlighted areas

Release Reviewed at Discharge with Patient and/or Parent/Guardian

________________________ __________
Signature (Prairie St. John's Staff) Date

___Send Records OR ____Send Only on Request