PRAIRIE ST. JOHN'S™

	______ Name of Patient	
	______ ______ DOB Phone Number	RM.204.F03
Authorization for Exchange of Protected Health Information	______ Maiden/Other Names	

I authorize Prairie St. John's, 510 4th Street South, Fargo, ND 58103 to Exchange confidential information with:

______________________________ ______________ ______________
(Name and Organization) (Telephone) (Fax #)

______________________________ ______________________________
(Street Address) (City, State, Zip Code)

Information will be faxed or mailed if no fax number is provided. We are unable to email protected health information.

Treatment from:

____Most Recent 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)

INFORMATION TO BE EXCHANGED:

Indicate Y/N	Document Exchange	Date Sent	Sent by Initials		Indicate Y/N	Document Exchange	Date Sent	Initials
	Psychiatric Assessment					Lab Results		
	Discharge Summary					Other: (Must Specify) ______________		
	Discharge Plans:					Psychological Consults/Testing		
	Discharge Medication List					Substance Use Evaluation		
	History & Physical							
	Medical Consults							

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 (must specify)__________________________
☐ 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 HIV/AIDS, mental health and any substance use (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