NUWAY
AUTHORIZATION TO RELEASE PROTECTED HEATLH INFORMATION

Full Legal Name: ____ Prior Aliases: _____________________________________

DOB: ________________ SSN: ______________________________ Phone #: _________________________ Client #: __________

Address: ____ City: ______________________ State: ________ Zip: _______________

1. I hereby authorize (NUWAY Administration and/or Specific Program)**:**

Phone: 612-767-0309 Fax: 651-925-0503

☐ **NUWAY Administration & Business Office**
2217 Nicollet Ave S., Minneapolis, MN 55404

☐ **St. Paul NUWAY Counseling Center**
545 7th Street West, St. Paul, MN 55102

☐ **NUWAY I – Residential Program**
2200 1st Ave S., Minneapolis, MN 55404

☐ **NUWAY II – Residential Program**
2518 1st Ave S., Minneapolis, MN 55404

☐ **3Rs NUWAY Counseling Center**
1404 Central Ave NE, Minneapolis, MN 55413

☐ **2118 NUWAY Counseling Center**
2118 Blaisdell Ave S., Minneapolis, MN 55404

2. To ☐ Obtain ☒ Release ☒ Exchange Information To/From:

Name: ____ Company/Organization: _______________________________

Relation to Client: ____________________________ Phone #: _________________________ Fax #: _____________________

Address: ____ City: ______________________ State: ________ Zip: __________

3. Purpose of Release (check all that apply)**:**

___ Treatment/Continued Care ___ Evaluation/Assessment ___ Personal ___ Legal Purposes ____ Transfer of Care

___ Disability Determination ___Payment of Insurance Claim ___ Application for Insurance ____ Emergency

___ Diagnostic Assessment ___ Other (Specify):____

4. Information to be Released (check all that apply)**:**

___ Evaluations/Assessments ___ Clinical Documentation ___ Medical ___ Labs ___ Billing ___ Past records of 2 years

___ Progress/Non-Progress ___ Attendance ___ Letter of Involvement ___ Continuum of Care recommendations

___ Discharge Summary/Information ____ Emergency Information ___ Other: (Specify): ________________________

5. For Dates of Service (mm/dd/yy): ________/________/________ through ________/________/________

6. _____ **I authorize the release of health information specified above that is created after the date of my signature for one year**.

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 4 CFR Parts160 & 164, Subparts A & E and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand the information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment. This authorization may be revoked at any time except to the extent that NUWAY has already taken action in reliance on it. NUWAY will not condition treatment on whether or not I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. It is understood that where federal laws or state laws relating to the court system apply, they should take precedence over any expiration or revocation expressed. I understand this release will terminate one year from date signed unless specified here (Specify date if less than one year): ____________________

_____________________________________ ________________ _____________________________________
Signature (Required) Date (Required) Printed Name

_____________________________________ ________________ _____________________________________
Signature of Client Representative (if needed) Date (Required) Printed Name

INSTRUCTIONS ON HOW TO FILL OUT THE RELEASE OF INFORMATION:

AUTHORIZATION TO RELEASE PROTECTED HEATLH INFORMATION

Full Legal Name: ______________________ Prior Aliases: ______________________

DOB: __________ SSN: ______________ Phone #: __________

Address: ______________________ City: __________ State: ______ Zip: ______

ENTER CLIENT INFORMATION HERE
(LEAVE CLIENT # BLANK)

1. I hereby authorize (NUWAY Administration and/or Specific Program):

Phone: 612-767-0309 Fax: 651-925-0503

☐ **NUWAY Administration & Business Office**
2217 Nicollet Ave S., Minneapolis, MN 55404

☐ **St. Paul NUWAY Counseling Center**
545 7th Street West, St. Paul, MN 5510

☐ **NUWAY I – Residential Program**
2200 1st Ave S., Minneapolis, MN 55404

☐ **NUWAY II – Residential Program**
2518 1st Ave S., Minneapolis, MN 5540

☐ **3Rs NUWAY Counseling Center**
1404 Central Ave NE, Minneapolis, MN 55413

☐ **2118 NUWAY Counseling Center**
2118 Blaisdell Ave S., Minneapolis, MN 55404

1.Check YOUR NUWAY location AND the NUWAY administration box

2. **To ☐ Obtain ☒ Release ☒ Exchange Information To/From:**

Name: ______________________ Company/Organization: ______________

Relation to Client: ______________ Phone #: ______________ Fax #: ______

Address: ______________________ City: ______________ State: ______ Zi

2.Fill in all information for where/who you want to have us send records to

3. **Purpose of Release** (check all that apply):

___ Treatment/Continued Care ___ Evaluation/Assessment ___ Personal ___ Legal Purposes ___ Transfe
___ Disability Determination ___Payment of Insurance Claim ___ Application for Insurance ___ Emerge
___ Diagnostic Assessment ___ Other (Specify):______________________

3.Check the accurate purpose of release line

4. **Information to be Released** (check all that apply):

___ Evaluations/Assessments ___ Clinical Documentation ___ Medical ___ Labs ___ Billing ___ Past recor
___ Progress/Non-Progress ___ Attendance ___ Letter of Involvement ___ Continuum of Care recommendati
___ Discharge Summary/Information ___ Emergency Information ___ Other: (Specify): __________

4.Be specific on what you would like released, fill out other line if you do not see your option listed

5. For Dates of Service (mm/dd/yy): ______/______/______ through ______/______/

5.Fill in the dates of service for client's treatment timeframe

6. ______ **I authorize the release of health information specified above that is created after the date of my signature for one year.**

6.Client needs to initial

...hat my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient ...FR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 4 CFR Parts160 & 164, Subparts ...not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand the information to be released may include records relate... ...ohol and drug abuse treatment. This authorization may be revoked at any time except... ...on in reliance on it. NUWAY will not condition treatment on whether or not I sign the au... ...nt to this authorization may be subject to re-disclosure by the recipient and may no lo... ...d that where federal laws or state laws relating to the court system apply, they sho... ...ation expressed. I understand this release will terminate one year from date signed u... ...year):

This is optional to initial, allows the client to dictate a date after which no more records can be released per this ROI

____

______________________ ______________ ______________________
Signature (Required) Date (Required) Printed Name

______________________ ______________________
Signature of Client Representative ...nted Name

Client must sign, date and print name, no representative required.