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: 612-925-0503

☐ **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 House, Inc. 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:

ENTER CLIENT INFORMATION HERE
(LEAVE CLIENT # BLANK)

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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: _____ Zip: _____

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 ___ Transf
___ Disability Determination ___ Payment of Insurance Claim ___ Application for Insurance ___ Emerg
___ 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 records of 2 years
___ Progress/Non-Progress ___ Attendance ___ Letter of Involvement ___ Continuum of Care recommendations
___ 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 [illegible] **above that is created after the date of my signature for one year.**

6.Client needs to initial

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 CF[illegible] A & E and cannot be disclosed without my written consent unless otherwise provided for in the regulations. [illegible] information to be released may include records related to behavior and/or mental health care and/or alcohol[illegible] This authorization may be revoked at any time except to the extent that NUWAY House, Inc. has already ta[illegible] NUWAY will not condition treatment on whether or not I sign the authorization. Information used or disclose[illegible] authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law[illegible] where federal laws or state laws relating to the court system apply, they should take precedence over any e[illegible] expressed. I understand this release will terminate one year from date signed unless specified here (Specify date if less than one 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

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

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