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
- ☐ **NUWAY I – Residential Program**
  2200 1st Ave S., Minneapolis, MN 55404
- ☐ **NUWAY II – Residential Program**
  2518 1st Ave S., Minneapolis, MN 55404
- ☐ **2118 NUWAY Counseling Center**
  2118 Blaisdell Ave S., Minneapolis, MN 55404
- ☐ **3Rs NUWAY Counseling Center**
  1404 Central Ave NE, Minneapolis, MN 55413
- ☐ **St. Paul NUWAY Counseling Center- 7th Street**
  545 7th Street West, St. Paul, MN 55102
- ☐ **NUWAY University Counseling Center**
  1246 University Ave W, St. Paul, MN 55104
- ☐ **Rochester NUWAY Counseling Center**
  300 11th Ave NW, Suite 120, Rochester, MN 55901

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)**:**

___ Assessments/Summaries ____ Treatment Plans and Reviews ____ Medications ___ UA/Labs
___ Progress Updates/Information ____ Mental Health Assessment/Notes/Reviews ____ Progress/Group Notes ___ Diagnosis
___ Discharge Summary ____Medical History ____ Other: (Specify): _____

5. Dates of Service: ____/_____/_____ to ____/_____/_____ OR ☒ **ALL DATES OF SERVICE**

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

7. _____I also understand that information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment.

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: _____ St

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 55102

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☐ **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: _____ 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 ___ Transfer of C
___ Disability Determination ___ Payment of Insurance Claim ___ Application for Insurance ___ Emergency
___ Diagnostic Assessment ___ Other (Specify):_____

3.Check the accurate purpose of release line

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

___ Assessments/Summaries ___ Treatment Plans and Reviews ___ Medications ___
___ Progress Updates/Information ___ Mental Health Assessment/Notes/Reviews ___ Progress/Group Notes ___
___ Discharge Summary ___ Medical History ___ Other: (Specify): _____

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

5. Dates of Service: ____/_____/_____ to ____/_____/_____ OR ☐ **ALL DATES OF SERVICE**

5.Select All dates or a specific 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

7. _____I also understand that information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment.

7.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 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 behs
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not condition treatment on whether or not I sign the authorizat
subject to re-disclosure by the recipient and may no longer be
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): _____

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

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

_____ _____ _____
Signature (Required) Date (Required) Printed Name

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