



INSTRUCTIONS ON HOW TO FILL OUT THE RELEASE OF INFORMATION:

AUTHORIZATION TO RELEASE PROTECTED HEALTH 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):

- 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
 - NUWAY-Duluth Counseling Center
4615 Grand Ave W, Suite 300, Duluth, MN 55807
 - 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
- Medical Records Fax Number: 651-925-0503

1. Check YOUR NUWAY location AND the NUWAY administration box

Use this Fax # for medical record requests

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 Care
- 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 UAI
- Progress Updates/Information Mental Health Assessment/Notes/Reviews Progress/Group Notes Discharge Summary
- 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 Parts 160 & 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 not condition treatment on whether or not I sign the authorization. Information use is subject to re-disclosure by the recipient and may no longer be protected by federal 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

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 _____