NUWAY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Legal Name: _____ Prior Aliases: _____

DOB: _____ SSN: _____ Phone #: _____ Client #: _____

Address: _____ City: _____ State: _____ Zip: _____

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

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

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

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

☐ **NUWAY III – Women's Residential Program**
2104 Stevens Ave., 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**
545 7th Street West, St. Paul, MN 55102

☐ **NUWAY University Counseling Center**
1246 University Ave W., St. Paul, MN 55104

☐ **NUWAY Rochester Counseling Center**
300 11th Ave NW, Ste 120, Rochester, MN 55901

☐ **NUWAY Duluth Counseling Center**
4615 Grand Ave W., Ste 300, Duluth, MN 55807

Medical Records Fax Number: 651-925-0503

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 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 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 my 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 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

☐ **NUWAY I – Me**
2200 1st Ave S

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

☐ **NUWAY III – Women's Residential Program**
2104 Stevens Ave., 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**
545 7th Street West, St. Paul, MN 55102

☐ **NUWAY University Counseling Center**
1246 University Ave W., St. Paul, MN 55104

☐ **NUWAY Rochester Counseling Center**
300 11th Ave NW, Ste 120, Rochester, MN 55901

☐ **NUWAY Duluth C**
4615 Grand Ave

1. Check YOUR NUWAY location AND the NUWAY administration box

Use this Fax # for medical record requests

Medical Records Fax Number: 651-925-0503

2. To ☐ **Obtain** ☐ **Release** ☐ **Exchange**

Name:_____

Relation to Client:_____ Ph

Address:_____

2. Select either 'Obtain', 'Release', or 'Exchange Information' and Fill in all information for where/who you want to have us send records to. 'Exchange Information' will allow for two-way communication

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

___Treatment/Continued Care ___Evaluation/Assessme ___gal Purposes ___Transfer of Care

___Disability Determination ___Payment of Insurance ___rance ___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 a ___UA/Labs

___Progress Updates/Information ___Mental Health Ass ___otes ___Diagnosis

___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 OF SERVICE' or a specific time frame

6. ___I authorize the ___ion sp___te of my signature for o___

6. Client needs to initial

7. ___I also understa___eleased 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 already taken action in reliance on it. NUWAY will not condi___ disclosed pursuant to this authorization may be___ law. It is understood that where federal laws o___ any expiration or revocation expressed. I under___ (Specify date if less than one year): _____

This is optional to initial. It 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 (if ___

Client must sign, date, and print name

No representative required