COCHRAN RECOVERY SERVICES, INC.
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Legal Name:_____ Prior Aliases: _____

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

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

1. I hereby authorize NUWAY ALLIANCE (Medical Records and/or Specific Program):

☐ **Cochran Recovery Services, Inc.**
1294 East 18th St., Hastings, MN 55033

Medical Records

Phone: 651-359-2073 **| Fax:** 651-925-0503 **| Address:** 1246 University Ave W., St. Paul, MN 55104

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):

___ Coordination of Care ____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. ___I authorize the release of health information for <u>ALL Dates of Service</u> unless indicated for the following timeframe: ___/___ /_____ to ___/____/_____.

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)

_____ _____ _____
Signature of Client Representative (If applicable) Printed Name Date (If applicable)

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: _____

1. ENTER YOUR INFORMATION HERE
(LEAVE CLIENT # BLANK)

1. **I hereby authorize NUWAY ALLIANCE** (Medical Records and/or Specific Program):

☐ **C** **es, Inc.**

2. Check this box

ngs, MN 55033

Medical Records

Phone: 651-359-2073 **| Fax:** 651-925-0503 **| Address:** 1246 University Ave W., St. Paul, MN 55104

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

3. 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

Name:_____

Relation to Client:_____ Ph

Address:_____

3. **Purpose of Release** (check

4. Select a purpose.

___ Coordination of Care ___Other (Specify): _____

Information to be Released (check all that apply):

5. Be specific on what you would like released. Fill out 'other' line if you do not see your option listed.

___Assessments/Summaries ___Treatment Plans and Reviews UA/Labs

___Progress Updates/Information ___Mental Health Assessment/N Diagnosis

___Discharge Summary ___Medical History ___Oth _____

4. **___I authorize the release of health information for the following timeframe: ___/___ /_____ to ___/____/_**

6. Initial to show agreement to **all dates of service**, otherwise indicate specific date timeframe.

5. **____I authorize on sp te of my signature f**

7. Initial to show agreement.

6. **____I also und leased may include records related to behavior and/or menta drug abuse treatment.**

8. Initial to show agreement.

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 may no longer be protected by federal law. It is understood that where federal laws or s any expiration or revocation expressed. I underst (Specify date if less than one year): _____

Optional: ROIs expire after one year from signature. If you put a date here, it will expire on that date, if sooner than a year.

_____ _____

Signature (Required) Date (Required)

REQUIRED: Signature and date

_____ _____ _____

Signature of Client Representative (If applicable) Printed Name Date (If applicable)