NUWAY ALLIANCE
AUTHORIZATION TO RELEASE PROTECTED HEATLH INFORMATION

Full Legal Name: _____ Prior Aliases: _____

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

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

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

- ☒ **NUWAY Alliance Admin & Medical Records**
  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
- ☐ **NUWAY St. Cloud Counseling Center**
  1420 W. St. Germain St., Ste 104, St. Cloud, MN 56301
- ☐ **The Gables**
  604 5th Street SW, Rochester, MN 55902
- ☐ **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
- ☐ **NUWAY Rochester Counseling Center**
  300 11th Ave NW, Suite 120, Rochester, MN 55901
- ☐ **NUWAY Duluth Counseling Center**
  4615 Grand Ave W, Suite 300, Duluth, MN 55807
- ☐ **NUWAY Mankato Counseling Center**
  802 S. Front St., Mankato, MN 56001

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 protected health information for <u>ALL Dates of Service</u> *unless* indicated for the following timeframe: _____ to _____.

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 behavioral 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 Alliance has already taken action in reliance on it. NUWAY Alliance 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)

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

INSTRUCTIONS TO FILL OUT THE RELEASE OF INFORMATION:

NUWAY ALLIANCE
AUTHORIZATION TO RELEASE PROTECTED HEATLH INFORMATION

Full Legal Name: _____ P

DOB: _____ SSN: _____ Phon

ENTER YOUR INFORMATION HERE.
(LEAVE CLIENT # BLANK)

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

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

- ☐ **NUWAY Alliance Admin & Medical Records**
  2217 Nicollet Ave S., Minneapolis, MN 55404
- ☐ **NUWAY I – Men's Residential Program**
  2200 1st Ave S., Minneapolis, MN
- ☐ **NUWAY II – Men's Residential Pr**
  2518 1st Ave S., Minneapolis, MN
- ☐ **NUWAY III – Women's Residentia**
  2104 Stevens Ave., Minneapolis, M
- ☐ **2118 NUWAY Counseling Center**
  2118 Blaisdell Ave S., Minneapolis, MN 55404
- ☐ **NUWAY St. Cloud Counseling Center**
  1420 W. St. Germain St., Ste 104, St. Cloud, MN 56301
- ☐ **The Gables**
  604 5th Street SW, Rochester, MN 55902
- ☐ **3Rs NUWAY Counseling Center**
  1404 Central Ave NE, Minneapolis, MN 55413
- ☐ **St. Paul NUWAY Counseling Center- 7th Street**
  t. Paul, MN 55102
- ☐ **unseling Center**
  , St. Paul, MN 55104
- ☐ **unseling Center**
  e 120, Rochester, MN 55901
- ☐ **NUWAY Duluth Counseling Center**
  4615 Grand Ave W, Suite 300, Duluth, MN 55807
- ☐ **NUWAY Mankato Counseling Center**
  803 S. Front St., Mankato, MN 56001

NUWAY Administration & Medical Records is pre-checked. You may also select the location(s) you attended and would like records from.

2. To ☐ Obtain ☒ Release ☒ Exchange Information To/From:

Name: _____

Relation to Client: _____ Fax #: _____

Address: _____ State: _____ Zip: _____

Fill in all information for who/where you want us to send records to.

3. Purpose of Release (check a

☐ Coordination of Care ☐ Other (Specify): _____

Coordination of care is pre-selected, but you may add your own.

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

☐ Assessments/Summaries ☐ Treatment Plans and Revie ☐ UA/Labs

☐ Progress Updates/Information ☐ Mental Health Assessment/ ☐ Diagnosis

☐ Discharge Summary ☐ Medical History ☐ _____

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

5. I authorize the release of protected h owing timeframe: _____ to _____.

You agree to have us send records from **all days you attended treatment**. If not, put a specific date timeframe.

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 behavioral 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 Alliance has already taken action in reliance on it. NUWAY Alliance will not condition treatment on whether or not I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to understood that where federal laws or state laws revocation expressed.

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.

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)

REQUIRED: Your signature and date

_____ _____ _____

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