



NUWAY ALLIANCE
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Legal Name: \_\_\_\_\_ Prior Aliases: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone #: \_\_\_\_\_

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 S., 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 112, 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
Cochran Recovery Services
1294 18th Street E. Hastings, MN 55033

I understand that this release of information covers all entities controlled or managed by NUWAY Alliance, which includes NUWAY, Cochran Recovery Services, The Gables, and NUWAY Recovery Foundation as listed above. If I would like to exclude the disclosure of records from any location above, I will identify that location(s) here: \_\_\_\_\_

2. To [ ] Obtain [x] Release [x] 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 & 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 ALL Dates of Service.

ONLY if I would like to limit the timeframe disclosed, I will indicate the timeframe here: \_\_\_\_\_ 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 of Client Representative

Date (if applicable)

# INSTRUCTIONS TO FILL OUT NUWAY ALLIANCE RELEASE OF INFORMATION:

Full Legal Name: \_\_\_\_\_ Prior Aliases: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

ENTER YOUR INFORMATION HERE.

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 1<sup>st</sup> Ave S., Minneapolis, MN 55404
- NUWAY II – Men’s Residential Program**  
2518 1<sup>st</sup> Ave S., Minneapolis, MN 55404
- NUWAY III – Women’s Residential Program**  
2104 Stevens Ave S., Minneapolis, MN 55404
- 2118 NUWAY Counseling Center**  
2118 Blaisdell Ave S., Minneapolis, MN 55404
- NUWAY St. Cloud Counseling Center**

- 3Rs NUWAY Counseling Center**  
1404 Central Ave NE, Minneapolis, MN 55413
- St. Paul NUWAY Counseling Center- 7<sup>th</sup> 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 11<sup>th</sup> Ave NW, Suite 112, 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
- Cochran Recovery Services**  
1294 18<sup>th</sup> Street E. Hastings, MN 55033

This release allows for records to be sent from all NUWAY Alliance programs listed. Please ONLY write location(s) on the line below if you DON'T want us to release records from those locations.

ed or managed by NUWAY Alliance, which includes NUWAY, Cochran Recovery  
If I would like to exclude the disclosure of records from any location above, I

will identify that location(s) here: \_\_\_\_\_

2. To  Obtain  Release  Exchange Information To/From:

Name: \_\_\_\_\_  
Relation to Client: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Fax #: \_\_\_\_\_

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

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

Coordination of Care

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

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

Assessments/Summaries

Tre

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

UA/Labs

Progress Updates/Information

Me

Progress/Group Notes

Diagnosis

Discharge Summary

Me

Other (Specify): \_\_\_\_\_

5. I authorize the release of \_\_\_\_\_

ONLY if I would like to limit \_\_\_\_\_

You agree to have us send records from all days you attended treatment. If not, put a specific date 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 by the recipient and may no longer be protected by federal law, apply, they should take precedence over any expiration or revocation.

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 of Client Representative

Date (if applicable)