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
423 Great Oak Drive, Waite Park, MN 56387
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
1884 22nd St. NW, 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
2000 White Bear Ave N, Maplewood, MN 55109

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 ☒ 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 & 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: _____

ENTER YOUR INFORMATION HERE.

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
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
1884 22nd St. NW, 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

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: _____ Fax #: _____

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

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

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 edications ☐ UA/Labs
☐ Progress Updates/Information ☐ Me ogress/Group Notes ☐ Diagnosis
☐ Discharge Summary ☐ Me ther (Specify): _____

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

5. **I authorize the release of**
ONLY if I would like to limi _____ 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. Informatio
by the recipient and may no longer be protected by federal law.
apply, they should take precedence over any expiration or revo

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)*