Release of Information

CLIENT INFORMATION

Legal Name: _____ Last Name: _____

Preferred Name: _____ Last Name: _____

Date of Birth: _____

This form may be used to authorize Alluma to obtain Protected Health Information about you from other agencies or individuals. It may also be used to authorize Alluma to send or provide your Health Information to other agencies or individuals.

I authorize Alluma to do the following:

☐ Obtain From (One-Way: Alluma gets information) _____

☐ Release To (One-Way: Alluma gives information) _____

☐ Exchange With (Two-Way: Alluma gets and gives information) _____

Request to disclose or obtain information from: _____

(Only 1 entity per Release of Information)

Purpose:

☐ Coordination of Care

☐ Personal Use

☐ Other: _____

Regarding

☐ Billing Records

☐ Chemical Dependency/Substance Abuse Reports

☐ Comprehensive Assessment (SUD)

☐ Consultations

☐ Comprehensive Evaluation/Diagnostic Assessment

☐ Discharge Summary

☐ Educational Informational

☐ Crisis Documentation/Emergency Reports

☐ History and Physical Exams

☐ Medical/Labroratory Records

☐ Medication List

☐ Progress/Provider Notes

☐ Psychiatric Reports

☐ Psychological Testing

☐ Treatment/Service Plan

☐ Other: _____

All information regarding alcohol and/or drug abuse will be released unless you restrict by initialing:

_____

- I understand that Alluma may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.293, WI Administrative Code HHS117, NDCC 23-12-14, Federal Rule 45 CFR 164.524; Charges may apply in ID. I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as the original.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that this authorization lasts for one year after the date of signature unless specified otherwise.

☐ I wish for this authorization to expire prior to one year after the date of signature.

Date of Authorization Expiration: _____

ATTENTION: This is a legal document. Please read carefully.

By signing, you agree that you understand and accept the terms in this form.

- If the client is 18 years of age or older, the clients must sign and date the form.
- If the client is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
- If the client is 17 years of age or younger, the client's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Print Name of Authorized Signee: _____

☐ I am 18 years of age or older and will be signing this form
☐ Client is 18 years of age or older and is incapable of signing
☐ Client is 17 years of age or younger
☐ I am 17 years of age or younger, but can sign due to a legal exception (please indicate)
  ☐ I am married
  ☐ I am a parent of a child
  ☐ I am legally emancipated
  ☐ I am a SUD client
  ☐ Other: _____

Signature: _____

My signature indicates that I am legally authorized to sign

Date: _____