

BRIGHTWATER HEALTH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BRIGHTWATER HEALTH located at:

- All BRIGHTWATER HEALTH Locations (See Primary Agency Address below)
- 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- 810 E. 4th Street, Duluth, MN 55805
- 120 W. 2nd Street, Duluth, MN 55802

- 325 11th Ave., Two Harbors, MN 55616
- 1500 N. 34th Street, Suite #100, Superior, WI 54880
- 40 11th Street, Cloquet, MN 55720
- Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

Name: _____
Last, First, MI

Previous Name: _____
Birth date: _____

I authorize BRIGHTWATER HEALTH and its staff/providers to: (check all that apply) release to obtain from verbal exchange with

Agency or Individual: _____

Address: _____

Method of Disclosure: Fax: _____ Email: _____
 Pick-up (Phone Number): _____ Mail

Purpose of this disclosure:

- Continuing Care/Treatment Planning
- Social Services Involvement
- Personal Records
- Legal
- Other Purpose (Specify): _____

Dates of service to be released:

- All dates of service
- Specific dates: _____

(If left blank, the most recent service note will be released)

The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)

- Medical History/History and Physical Exam
- Medication Records
- Discharge Summary
- Chemical Dependency/Substance Use Notes
- Progress Notes
- Treatment Plan
- Social Services Reports/Interventions
- Emergency Room Records
- Lab Results
- School Reports: Grades, Behaviors, IEP
- Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
- Other (Specify Record Type(s): _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.

- Substance Abuse
- HIV Test Results
- Mental Health

- This authorization expires one year from the date of signature, unless a different expiration date is entered here: _____
- I may revoke (cancel) this authorization in writing at any time. A revocation will not apply to information already released under this authorization
- BRIGHTWATER HEALTH's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- BRIGHTWATER HEALTH will not put conditions on my treatment, payment, or eligibility on whether I sign this authorization.
- A photocopy/fax of this authorization is as valid as the original.
- Records released may include information received from other providers/agencies.
- BRIGHTWATER HEALTH cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release BRIGHTWATER HEALTH from all liability resulting from a re-disclosure by the recipient.
- Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further re-disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR, Part II.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be responsible for fees related to retrieval and photocopying of records and/or supervising inspection of records.
- You have the right to receive a copy of this signed authorization.

By signing below, I confirm I have read and understand this authorization and give permission for release of my information as described above.

Signature of Client / Parent / Legal Representative: _____ Date: _____

If signed by someone other than client, relationship to client: _____