Arubah Emotional Health Services
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client Name (Last, first, middle initial)

Street Address City State Zip

Date of Birth Day Phone # Evening Phone #

INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH
Name (Program / Individual) **Arubah Emotional Health Services**	Name (Program / Individual)
Street Address	Street Address
City State Zip	City State Zip
Telephone: Fax:	Telephone: Fax:

AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING: FROM: _____ TO _____

☐ Admission / Intake Summary ☐ Diagnosis & Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ Psychiatric Assessment ☐ Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment ☐ Psychological Assessment
☐ Prior Treatment Records ☐ Medication Management Records ☐ Medical/Physical History ☐ Education Records

☐ Progress Review ☐ HIV History ☐ Billing Records/Statements (date)_____

☐ Other _____

-OR-

☐ **The entire record** (including, if applicable, chemical dependency/drug or alcohol abuse treatment records)

AND ☐ ***including*** billing records ☐ ***excluding*** billing records ☐ ***excluding*** records from other facilities ☐ ***excluding*** HIV records

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THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

☐ Insurance Payment ☐ Third Party Authorization and Payment ☐ Communication regarding legal issues
☐ Coordination of Care ☐ Litigation ☐ Other _____

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Arubah Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Arubah Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released from any and all liability resulting from re-disclosure.

Client / Legal Representative Signature _____ Dated _____

If you are the client's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative. **You are entitled to a copy of this document**