A BETTER CONNECTION, INC.
1009 Hollinger Street
Park Rapids, MN 56470
OFFICE: 218-252-2785 FAX: 218-732-4695
www.abetterconnectioninc.com

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

Patient Name:_____ _____
First Name Middle Initial Last Name Date of Birth

_____ _____
Address City State Zip Phone Number

1. I hereby authorize _A Better Connection, Inc._____ to:_____ obtain my information
_____ release my information

_____
From: Agency, Facility, or Individuals Name, Address

Phone: _____
Fax: _____

2. Information to be released is for **ALL DATES** of service unless specified here:_____

Yes No Progress Notes	Yes No Diagnostic Assessment	Yes No Treatment Summary
Yes No Psychological Evaluation	Yes No Educational Information	Yes No Psychiatric Evaluation
Yes No Chemical Dependency	Yes No Medical History & Treatment	Yes No Court/Probation Info
Yes No Discharge Summary	Yes No Medication List	
Yes No Lab Work	Yes No Other-specify_____	

3. The above information is release for the following purpose and that purpose only:

_____Treatment Planning ____Coordination of Services _____Other (Please Explain)

I understand that:

-The information will be used for the purpose specified and will not be disclosed to other sources unless specifically authorized by law.
-I may refuse to release this information and the consequences of this refusal have been explained to me.
-I may revoke this consent at any time, not retroactively, and that such revocation must be in writing.
-The information to be exchanged will be treated as private or confidential as governed by MN Government Data Practices Act, M.S. 13.01 to 13.88 and Federal regulations (42 CFR42 Part 2).
-This authorization will permit two-way telephone communication between the agencies or individuals listed above. -This information may not be disclosed to anyone else other than those agencies or individuals listed above unless written permission is provided.
-I consent that a copy of this signed consent may be used in the same way and under the same restrictions as the original. -I understand that when the health information specified is released to the third party named above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy law.
-Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records.

This consent will end <u>one year</u> from the date the form is signed unless I indicate an earlier date, event or condition here:

Date_____ Or Specific Event or Condition _____

_____ _____
Patient's Signature **Date**

_____ _____
Signature of Parent or Legal Guardian-Relationship to Patient if other than parent or Legal Guardian.Please attach documentation to prove signing authority **Witness**