Lutheran Social Services of North Dakota

Authorization for Release of Information

Name of Client: _____ _____ _____
[Last, First, Middle] [Maiden] [DOB]

Address: _____ SS #: _____
[Street, City, State, Zip]

I hereby authorize _____ to ____ **release information to /or**
[Person/Agency]

____ **receive information from** *(check both, if applicable)* _____
[Person/Agency]

The following information:

___ Psychiatric/Psychological/Mental Health Assessments, Diagnosis, Summaries, & Progress Reports
___ Medical Information: Reports, History, Testing, Lab Work,
___ Medical Information related to HIV(AIDS) or related illness
___ Family History, Information, & Participation
___ Admission & Discharge Summaries
___ Chemical Dependency Assessments, Information, Summaries
___ Educational Information, Transcripts, Current Grade Level, & Testing
___ Progress Reports
___ Past Placement Information & Recommendations
___ Legal History
___ Other: _____

This information identified above will be used for*: (May be communicated in written and/or verbal form)*

___ Family Involvement
___ Insurance Purposes
___ Social Services Involvement
___ Diagnosis/Treatment
___ Update Records
___ Other: _____
___ Education Involvement/IEP
___ Chemical Dependency Issues
___ Legal Involvement
___ Acknowledge Referral
___ Aftercare/Discharge Planning

This authorization remains in effect until _____

- Not to exceed 90 days from when authorization is given for a one-time release of information
- Not to exceed one (1) year, when a contracted or cooperating service provider requires the release of information for ongoing service provision or;
- As the law or court order requires.

CLIENT AUTHORIZATION: This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this form once I have signed it. I also understand that if the individual or organization receiving the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by these federal regulations. A photocopy of this release is as effective as the original.

_____ _____
Signature of Client / Date Signature of Legal Custodian / Date

_____ _____
Signature of Parent / Date Signature of Witness / Date

____ Check if applicable--Notice to whomever disclosure is made concerning addiction records.

This information released subject to confidentiality provision of section 33 of Public Law 93-282, Federal Statutes 21.U.S.C. 1175 (42-CFR-Part 2), and NDCC 14-15-16, 23-07.03, 25-16-07, 50-11.1-07, 25-03,1.42 which prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Revised 5/11/09