Avera Partner

117 S. Spring Street, P.O. Box 686, Luverne, MN 56156, 507-283-9511
1016 8th Ave SW, P.O. Box 85, Pipestone, MN 56164, 507-825-5888
1210 5th Ave, P.O. Box 175, Worthington, MN 56187, 507-376-4141
41385 US Hwy 71, P.O. Box 353, Windom, MN 56101, 507-831-2090
401 West Street, Suite 0115, Jackson, MN 56143, 507-847-2423

Patient Identification	Client Name: ______ DOB: ______ Address: ______ City/State/Zip: ______ Social Security Number (last 4 digits): ______ Phone: ______
Provider	Provider Name: Southwestern Mental Health Center
☐ **Obtain Information From:** ☐ **Release Information**	Name/Facility: ______ Address: ______ City/State/Zip: ______ Phone: ______ Fax: ______
Information to be Disclosed	___ Diagnostic Assessment/Psychiatric Evaluation ___ Most Recent History & Physical ___ Drug Screening ___ Summary of Treatment Contacts ___ Psychological Testing ___ Chemical Dependency Evaluation ___ Discharge Summary ___ Ongoing Exchange of Information ___ ARMHS: FA, Social Services Plan, ITP, IMR Recovery Goal Form
Service Dates	Dates of Service From (date): ______ to (date): ______
Form and Format:	___ Paper Records ___ Flash Drive ___ Fax ___ CD-Rom (compact disc) ___ Electronically by email (All e-mail transmissions will be encrypted unless specifically requested otherwise by the client. Sending medical records by unencrypted e-mail has risks including the individual's PHI could be read or otherwise accessed while in transit. File size may limit ability to send an e-mail). If you want your records sent unencrypted please initial here: ______. If you choose to receive your records by e-mail, please provide the requested e-mail address: ______
Substance Abuse Documentation	Check this box **ONLY** if you permit substance abuse records to be released. ___ Requestor take note: These released records contain substance abuse documentation, and therefore prohibition on **Documentation** re-disclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUTES (42 U.S.C. 290dd-2, & regulations 42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person it pertains, or as otherwise permitted by such regulations.
Purpose of Disclosure	___ Continued Healthcare ___ Completion/Payment ___ Personal ___ Other: ______
Expiration Date	Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______ If I fail to specify an expiration date, event or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: *Information already released in response to this authorization. * My insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the SWMHC Privacy Officer at (507) 283-9511. ______ Signature of Client or Legal Representative ______ Date ______ Witness Signature ______ Relationship to Client ______ Date