



# MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

ND DEPARTMENT OF HUMAN SERVICES

SFN 970 (Rev. 05-2003)

Initial:	Date:
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**PRIVACY STATEMENT:** Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose the social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

**INSTRUCTIONS:** Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

## CLIENT RELEASE AND SIGNATURE

I hereby authorize the following agencies/individuals to disclose information to and exchange the indicated information with: (Please place your initials in the boxes to the left indicating your authorization)

Name of Person/Organization:				Name of Person/Organization:			
Street Address:	City:	State:	Zip Code:	Street Address:	City:	State:	Zip Code:
To Disclose and Exchange the Following Information: <input type="checkbox"/> Verification of Treatment <input type="checkbox"/> Progress Reports <input type="checkbox"/> Assessment Results <input type="checkbox"/> Testing Results <input type="checkbox"/> Educational/Vocational Information <input type="checkbox"/> Child Abuse/Neglect Assessment/Results <input type="checkbox"/> Psychological Eval/Recommendations <input type="checkbox"/> Other _____ <input type="checkbox"/> Legal Status/Court Order <input type="checkbox"/> Other _____ <input type="checkbox"/> Psychiatric Eval/Recommendations <input type="checkbox"/> Other _____ <input type="checkbox"/> Medical Information <input type="checkbox"/> Other _____ <input type="checkbox"/> Addiction Eval/Recommendations <input type="checkbox"/> Other _____				To Disclose and Exchange the Following Information: <input type="checkbox"/> Verification of Treatment <input type="checkbox"/> Progress Reports <input type="checkbox"/> Assessment Results <input type="checkbox"/> Testing Results <input type="checkbox"/> Educational/Vocational Information <input type="checkbox"/> Child Abuse/Neglect Assessment/Results <input type="checkbox"/> Psychological Eval/Recommendations <input type="checkbox"/> Other _____ <input type="checkbox"/> Legal Status/Court Order <input type="checkbox"/> Other _____ <input type="checkbox"/> Psychiatric Eval/Recommendations <input type="checkbox"/> Other _____ <input type="checkbox"/> Medical Information <input type="checkbox"/> Other _____ <input type="checkbox"/> Addiction Eval/Recommendations <input type="checkbox"/> Other _____			
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