MULTI-AGENCY AUTHORIZATION TO DISCLOSE INFORMATION

ND DEPARTMENT OF HUMAN SERVICES

SFN 970 (Rev. 05-2003)

Initial:	Date:

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:

Pride Manchester House

Street Address:	City:	State:	Zip Code:
2600 Manchester Street	**Bismarck**	**ND**	**58504**

To Disclose and Exchange the Following Information:

- ☑ Verification of Treatment
- ☑ Progress Reports
- ☑ Assessment Results
- ☑ Testing Results
- ☑ Educational/Vocational Information
- ☐ Child Abuse/Neglect Assessment/Results
- ☑ Psychological Eval/Recommendations
- ☐ Other____________________
- ☐ Legal Status/Court Order
- ☐ Other____________________
- ☑ Psychiatric Eval/Recommendations
- ☐ Other____________________
- ☑ Medical Information
- ☐ Other____________________
- ☐ Addiction Eval/Recommendations
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The Information Identified Above will be Used For:

This Authorization to Disclose Information Remains in Effect Until: (Date) _____OR: (Specific Event Terminating Operation of the Release) _____

CLIENT CONSENT:

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. Refer to the notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Client:	Date:
Signature of Parent/Guardian or Custodian: (If Needed and Relationship)	Date:
Signature of Witness: (If Needed)	Date:

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by State or Federal Law.

☐ Check If Applicable: **NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS.** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

DISTRIBUTION: **Original -** To Agency/Person Completing Form
Copies - To Person/Organizations and Client