AMHERST H. WILDER FOUNDATION
Here for good.

Authorization for the Release of Records

Client First Name **Middle Initial** **Last Name**

Date of Birth **Client #** (if known)

Parties Sharing Information

Amherst H. Wilder Foundation | Wilder Programs | 451 Lexington Parkway N | St Paul, MN 55104 | 651-280-2101 (P) | 651-280-3995 (F)

I hereby authorize Amherst H. Wilder Foundation to: ☐ Exchange with ☐ Obtain from ☐ Release to

Facility/Individual Name Address (Street | Apt/Bldg | City | State | Zip)

Phone Fax

Wilder releases one year of records unless specific date range is selected:
For this specific time period: Start date: _____ End date: _____

Wilder will release your records containing mental health, substance use disorder or other health information including the following: If specific to Substance Use Disorder Treatment check box: ☐

- ☐ Assessments/Evaluations
- ☐ Visit/Progress Notes
- ☐ Court/Commitment Records
- ☐ School Communication & Records
- ☐ Entire Record
- ☐ Urinalysis/Blood Alcohol Results
- ☐ Treatment Plans
- ☐ Closings/Discharge Summaries
- ☐ Non-Wilder Third Party Service Records
- ☐ Medications
- ☐ Other _____

If client is under 18, only the minor may consent to the release of the following information:
☐ HIV/AIDS Status ☐ Sexually Transmitted Infections ☐ Substance Abuse

Reason for Release:

- ☐ Treatment/Continued Care/Coordination of Services
- ☐ Insurance/Payment
- ☐ Legal
- ☐ School Evaluation/Special Ed Needs
- ☐ Disability Benefits
- ☐ Other _____

Release Method: ☐ All ☐ Email: _____ ☐ Fax: _____
☐ Oral ☐ Postal Mail

Email Encryption? ☐ Yes ☐ No- Selecting this option means the information being sent could be visible to others and is not secure

This release will expire in one year unless indicated below. I Understand That by Signing This Authorization:

- My health information is protected by federal and state privacy laws and regulations. Disclosure/release is allowed only with my authorization except in limited circumstances as described in the Wilder Foundation Notice of Privacy Practices.
- I have a right to inspect and receive a copy of my records that may be released to others, as provided under applicable laws.
- I may revoke this authorization by notifying in writing the Wilder Foundation Medical Records team.This would not apply to actions already taken.
- Once Wilder releases records, Wilder cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws. Federal confidentiality regulations (42 CFR, part 2) prohibit re-disclosure of information from alcohol and drug abuse treatment records.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign this authorization.
- A photocopy of this form is as valid as the original and I will receive a copy of this signed form upon request.

Signature **Today's Date** **Indicate Relationship to the Client** (if applicable)

*** Notice Prohibiting Re-disclosure of Alcohol or Drug Abuse Information**

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or is 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 investigate or prosecute with regard to a crime any patient with a substance use disorder.

INSTRUCTIONS FOR COMPLETING AUTHORIZATION FORM

CLIENT INFORMATION	Clearly print the client's full name and date of birth. This information is used to identify your specific client information and to make certain that only your information is released.
PARTIES SHARING INFORMATION	❖ Print the name, address and phone number of the Wilder Program releasing the information. ❖ Print the name, address, phone number and fax of the person or organization authorized to receive this information.
INFORMATION TO BE RELEASED (Wilder's policy is to respond within thirty (30) days of receipt)	❖ Indicate what information is to be released by checking all of the boxes that apply. ❖ If can choose to limit information that is sent to a particular date(s) or year(s) by indicating that in the line provided. ❖ If you select Entire Client Record, the complete record will be sent except for the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted infection, HIV/AIDS related treatment, and/or mental health/psychological) ❖ You must specifically indicate your authorization to release sensitive information related to psychological/mental health diagnosis, status and treatment; alcohol and drug abuse diagnosis and treatment; HIV/AIDS Status, and sexually transmitted infections.
***NON-WILDER 3RD PARTY INFORMATION**	Wilder will only release third party information when specifically authorized and/or requested by client to do so. Wilder cannot guarantee the completeness of third party information or whether it represents the most-up-to date information available.
**** AUTHORIZATION FOR THE RELEASE OF SPECIFIC SENSITIVE INFORMATION**	Minnesota law allows a minor (a person under the age of 18) to consent for their own medical, mental or other health services to determine the presence of or to treat pregnancy and conditions associated with venereal disease and/or alcohol and other drug abuse (Minn. Stat. 144.343, Subd. 1). For this reason, Wilder will only release this information with the authorization of the minor and no additional authorization is required.
REASON FOR RELEASE	Indicate the reason for releasing the information by checking the appropriate box.
RELEASE METHOD & EMAIL ENCRYPTION	Check the appropriate box. Exchange with = giving and receiving records to facility/individual Obtain from = receiving records from facility/individual Release to = giving records to facility/individual (including yourself)
EXPIRATION	Expiration is when this authorization will end. Client has the option of indicating that the authorization will expire at the end of their treatment relationship with Wilder, on a specific date, or following a specific event. If none of these is selected, the authorization will expire one year from the date the form is signed. **NOTE: Consistent with the Minnesota Health Records Act, a consent [for the release of health records] is valid for one year or for a period specified in the consent or for a different period provided by law. See Minn. Stat. § 144.293, subd. 4.**
SIGNATURE AUTHORIZING THE RELEASE OF INFORMATION	If you are the individual whose information will be released or a parent authorizing the release of information, you must sign and date in this section. **For exceptions to parental authorization see **Authorization for the Release of Specific Sensitive Information above.** If you are the Personal Representative, the client's signature is not required. However, you must provide the requested information, signature, and date. A copy of the legal authority, such as a Health Care Directive naming you as an agent or other legal document, must be on file or submitted with this form.