



**NUWAY
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Full Legal Name: _____ Prior Aliases: _____

DOB: _____ SSN: _____ Phone #: _____ Client #: _____

Address: _____ City: _____ State: _____ Zip: _____

1. I hereby authorize NUWAY (Administration and/or Specific Program):

Phone: 612-767-0309 Fax: 651-925-0503

- | | |
|---|--|
| <input type="checkbox"/> NUWAY Administration & Business Office
2217 Nicollet Ave S., Minneapolis, MN 55404 | <input type="checkbox"/> St. Paul NUWAY Counseling Center
545 7th Street West, St. Paul, MN 55102 |
| <input type="checkbox"/> NUWAY I – Residential Program
2200 1 st Ave S., Minneapolis, MN 55404 | <input type="checkbox"/> NUWAY II – Residential Program
2518 1 st Ave S., Minneapolis, MN 55404 |
| <input type="checkbox"/> 3Rs NUWAY Counseling Center
1404 Central Ave NE, Minneapolis, MN 55413 | <input type="checkbox"/> 2118 NUWAY Counseling Center
2118 Blaisdell Ave S., Minneapolis, MN 55404 |

2. To Obtain Release Exchange Information To/From:

Name: _____ Company/Organization: _____

Relation to Client: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

3. Purpose of Release (check all that apply):

- Treatment/Continued Care Evaluation/Assessment Personal Legal Purposes Transfer of Care
 Disability Determination Payment of Insurance Claim Application for Insurance Emergency
 Diagnostic Assessment Other (Specify): _____

4. Information to be Released (check all that apply):

- Assessments/Summaries Treatment Plans and Reviews Medications UA/Labs
 Progress Updates/Information Mental Health Assessment/Notes/Reviews Progress/Group Notes Diagnosis
 Discharge Summary Medical History Other: (Specify): _____

5. Dates of Service: _____/_____/_____ to _____/_____/_____ OR ALL DATES OF SERVICE

6. _____ I authorize the release of health information specified above that is created after the date of my signature for one year.

7. _____ I also understand that information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment.

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 4 CFR Parts 160 & 164, Subparts A & E and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand the information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment. This authorization may be revoked at any time except to the extent that NUWAY has already taken action in reliance on it. NUWAY will not condition treatment on whether or not I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. It is understood that where federal laws or state laws relating to the court system apply, they should take precedence over any expiration or revocation expressed. I understand this release will terminate one year from date signed unless specified here (Specify date if less than one year): _____

Signature (Required) Date (Required) Printed Name

Signature of Client Representative (if needed) Date (Required) Printed Name



INSTRUCTIONS ON HOW TO FILL OUT THE RELEASE OF INFORMATION:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Legal Name: _____ Prior Aliases: _____
 DOB: _____ SSN: _____ Phone #: _____
 Address: _____ City: _____ State: _____

ENTER CLIENT INFORMATION HERE
(LEAVE CLIENT # BLANK)

1. I hereby authorize NUWAY (Administration and/or Specific Program):

Phone: 612-767-0309 Fax: 651-925-0503

- | | |
|---|---|
| <input checked="" type="checkbox"/> NUWAY Administration & Business Office
2217 Nicollet Ave S., Minneapolis, MN 55404 | <input type="checkbox"/> St. Paul NUWAY Counseling Center
545 7th Street West, St. Paul, MN 55102 |
| <input type="checkbox"/> NUWAY I – Residential Program
2200 1 st Ave S., Minneapolis, MN 55404 | <input type="checkbox"/> NUWAY II – Residential Program
2518 1 st Ave S., Minneapolis, MN 55404 |
| <input type="checkbox"/> 3Rs NUWAY Counseling Center
1404 Central Ave NE, Minneapolis, MN 55413 | <input type="checkbox"/> 2118 NUWAY Counseling Center
2118 Blaisdell Ave S., Minneapolis, MN 55404 |

1. Check YOUR NUWAY location AND the NUWAY administration box

2. To Obtain Release Exchange Information To/From:

Name: _____ Company/Organization: _____
 Relation to Client: _____ Phone #: _____ Fax #: _____
 Address: _____ City: _____ State: _____ Zip: _____

2. Fill in all information for where/who you want to have us send records to

3. Purpose of Release (check all that apply):

- Treatment/Continued Care Evaluation/Assessment Personal Legal Purposes Transfer of Care
 Disability Determination Payment of Insurance Claim Application for Insurance Emergency
 Diagnostic Assessment Other (Specify): _____

3. Check the accurate purpose of release line

4. Information to be Released (check all that apply):

- Assessments/Summaries Treatment Plans and Reviews Medications
 Progress Updates/Information Mental Health Assessment/Notes/Reviews Progress/Group Notes
 Discharge Summary Medical History Other: (Specify): _____

4. Be specific on what you would like released, fill out other line if you do not see your option listed

5. Dates of Service: ___/___/___ to ___/___/___ OR ALL DATES OF SERVICE

5. Select All dates or a specific timeframe

6. _____ I authorize the release of health information specified above that is created after the date of my signature for one year.

6. Client needs to initial

7. _____ I also understand that information to be released may include records related to behavior and/or mental health care and/or alcohol and drug abuse treatment.

7. Client needs to initial

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 4 CFR Parts 160 & 164, Subparts A & E and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand the information to be released may include records related to behavior and/or alcohol and drug abuse treatment. This authorization may be revoked at any time except to the extent that I have agreed to a specific condition of treatment on whether or not I sign the authorization. If state laws relating to the court system apply, they should take precedence over any expiration or revocation expressed. I understand this release will terminate one year from date signed unless specified here (Specify date if less than one year): _____

This is optional to initial, allows the client to dictate a date after which no more records can be released per this ROI

Client must sign, date and print name, no representative required.

Signature (Required) _____ Date (Required) _____ Printed Name _____

Signature of Client Representative (if needed) _____ Date (Required) _____ Printed Name _____