# NUWAY ALLIANCE
## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Full Legal Name: _____ Prior Aliases: _____

DOB: _____ SSN: _____ Phone #: _____

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

**1. I hereby authorize NUWAY ALLIANCE** (Administration/Medical Records and/or Specific Program(s))**:**

**NUWAY Alliance Admin & Medical Records**
2217 Nicollet Ave S., Minneapolis, MN 55404
**NUWAY I**
2200 1st Ave S., Minneapolis, MN 55404
**NUWAY II**
2518 1st Ave S., Minneapolis, MN 55404
**NUWAY III**
2104 Stevens Ave S., Minneapolis, MN 55404
**The Gables**
604 5th Street SW, Rochester, MN 55902

**3Rs NUWAY Counseling Center**
1404 Central Ave NE, Minneapolis, MN 55413
**2118 NUWAY Counseling Center**
2118 Blaisdell Ave S., Minneapolis, MN 55404
**NUWAY University Counseling Center**
1246 University Ave W, St. Paul, MN 55104
**Cochran Recovery Services**
2000 White Bear Ave N, Maplewood, MN 55109

*I understand that this release of information covers all entities controlled or managed by NUWAY Alliance, which includes NUWAY, Cochran Recovery Services, The Gables, and NUWAY Recovery Foundation as listed above.* ***If I would like to exclude the disclosure of records from any location above, I will identify that location(s) here:*** _____

**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)**:**

☒ Coordination of Care ☐ Other (Specify): _____

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

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

**5. I authorize the release of protected health information for ALL Dates of Service.**

ONLY if I would like to limit the timeframe disclosed, I will indicate the timeframe here: _____ to _____.

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 behavioral 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 Alliance has already taken action in reliance on it. NUWAY Alliance 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)**

_____ _____ _____
Signature of Client Representative *(If applicable)* Printed Name of Client Representative Date *(If applicable)*

# INSTRUCTIONS TO FILL OUT
# NUWAY ALLIANCE RELEASE OF INFORMATION:

Full Legal Name: _____ Prior Aliases: _____

DOB: _____ SSN: _____

ENTER YOUR INFORMATION HERE.

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

1. **I hereby authorize <u>NUWAY ALLIANCE</u>** (Administration/Medical Records and/or Specific Program(s)):

**NUWAY Alliance Admin & Medical Records**
2217 Nicollet Ave S., Minneapolis, MN 55404
**NUWAY I**
2200 1st Ave S., Minneapolis, MN 55404
**NUWAY II**
2518 1st Ave S., Minneapolis, MN 55404
**NUWAY III**

**3Rs NUWAY Counseling Center**
1404 Central Ave NE, Minneapolis, MN 55413
**2118 NUWAY Counseling Center**
2118 Blaisdell Ave S., Minneapolis, MN 55404
**NUWAY-University Counseling Center**
1246 University Ave W, St. Paul, MN 55104
**Cochran Recovery Services**
2000 White Bear Ave N, Maplewood, MN 55109

This release allows for records to be sent from all NUWAY Alliance programs listed. Please ONLY write location(s) on the line below if you **DON'T** want us to release records from those locations.

*ed or managed by NUWAY Alliance, which includes NUWAY, Cochran Recovery* ***If I would like to exclude the disclosure of records from any location above, I will identify that location(s) here:*** _____

2. **To ☐ Obtain ☒ Release ☒ Exchange Information To/From:**

Name: _____

Relation to Client: _____

Address: _____ Zip: _____

Fill in information for who/where you want us to send records. We DO NOT e-mail Protected Health Information. **ADDRESS OR FAX IS REQUIRED.**

3. **Purpose of Release** (Check all that apply):

☐ Coordination of Care

Coordination of Care is pre-selected, but you may add your own purpose.

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

☐ Assessments/Summaries ☐ Tre edications ☐ UA/Labs
☐ Progress Updates/Information ☐ Me ogress/Group Notes ☐ Diagnosis
☐ Discharge Summary ☐ Me ther (Specify): _____

Be specific on what you would like released. Fill out 'other' line if you do not see your option(s) listed.

5. **I authorize the release of**
ONLY if I would like to limi _____ to _____.

You agree to have us send records from **all days you attended treatment.** If not, put a specific date timeframe.

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 behavioral 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 Alliance has already taken action in reliance on it. NUWAY Alliance will not condition treatment on whether or not I sign the authorization. Informatio by the recipient and may no longer be protected by federal law. apply, they should take precedence over any expiration or revo

**Optional:** ROIs expire after one year from signature. If you put a date here, it will expire on that date, if sooner than a year.

**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)**

**REQUIRED:** Your signature and date.

_____ _____ _____
Signature of Client Representative *(If applicable)* Printed Name of Client Representative Date *(If applicable)*