

Information to be used or disclosed in connection with Pediatric Mental Health Care Access Program

Authorization for Disclosure of Protected Health Information

Patient Name:	Date of B	irth:	
Address:			
Phone Number:	Email:	-	
Instructions: Fill out each section of this form completely	=		
Authorizes Family Voices of ND to Release Information be Name/Facility:	tween the following agenc Consultar		
Address: (City/State/Zip Code)		_	
Phone Number:			
To Release Information To and From:			
Name/Facility: Phone No		umber:	
Address: (City/State/Zip Code)	Fax #:		
Purpose of Release:	<u>'</u>		
☐ Coordination of Care Planning☐ Acknowledgement of Services	☐ Application for Insurance ☐ Other:		
Information to be Released:			
☐ Assessment ☐ Diagno			
☐ Treatment Progress	☐ Demographic In	ıformation	
☐ Educational Information	☐ Other:		
Information may be Released by: ☐ Mail ☐ Pick-up ☐ Phone	e	□ Flootronic A /idea	
Authorization for this information remains in effect for 1 is provided. I may revoke this authorization at any time by sen revocation in not valid if (1) action was previously taken in reliar a condition for obtaining insurance coverage. I authorize the faction the "Release Information To and From" section. I understand use, and HIV treatment. I understand that once disclosed, information protected. I understand this authorization is voluntary and that affect my ability to obtain treatment, receive treatment, or my protected under federal regulations governing Confidentiality of cannot be disclosed without written consent unless otherwise p the signature of a minor 14 years and older is required to disclose minor 13 years and younger and the signature of the minor's leg substance use disorder information.	ding written notice to the factorice on this authorization, or (include information) and this may include information mation may be re-disclosed by I may refuse to sign. Unless all eligibility for benefits. SUBSTA f Substance Use Disorder Patierovided for in the regulations se substance use disorder information.	ility/provider releasing records. A 2) if this authorization was obtained as lical information to the party identified regarding mental health, alcohol/drug y the recipient and no longer llowed by law, my refusal will not ANCE USE DISORDER INFORMATION is ent Records; 42 C.F.R. Part 2 and is. In accordance with North Dakota law brmation. Both the signature of the	
Signature of client:		Date:	
Signature of Parent (Guardian)(required)		Date:	