AUTHORIZATION TO DISCLOSE INFORMATION



Good Road Recovery Center

MHA Nation: Good Road Recovery Center

1308 Elbowoods Ln, Bismarck ND 58503

Telephone 701-751-8260 | Fax 701-751-2274

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. Good Road Recovery Center will not condition treatment on your agreement to authorize disclosure of your health information. Good Road Recovery Center 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 health plan.

Name (Last, First, Middle Initial)	Social Security Number		Date of Birth	
Previous Names Used			Telephone Number	
Current Address	City	State		ZIP Code
CLIENT RELEASE AND SIGNATURE				
1. I Hereby Authorize:				
MHA Nation: Good Road Recovery Center, 1308 Elbowoods Ln, Bismarck, ND 58503				
2. Permission To: Disclose To Obtain From	Mutually Exchange With			
Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)			
Street Address	City	State		ZIP Code
3. The authorizations allows the disclosure and exchange of verbal, written, and electronic communication and is restricted to the following				
requested designated records: (check all that apply)	Evaluation/Assessment Progress			
Addiction* Attendance D	Any Drug Screening	Court/Legal		Collateral
□ Educational □ Medical □ □ Other (must specify to be valid):	5			
4. The information identified above will be used for: (select all that apply)		At the Reques	st of the Individ	ual
		Court/Legal Is Referral	sues	Medical
5. Authorization remains in effect for two years from date signed unless a different expiration date is entered here (MM/DD/YYYY): Date:				
CLIENT CONSENT				
This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to Good Road Recovery Center's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original. Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws. SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.				
Signature of Client		Date		
Signature of Parent/Guardian or Custodian (if needed)	Relationship		Date	
Signature of Witness (if needed)			Date	
CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING SUBSTANCE USE DISORDER PATIENT RECORDS:				
This information has been disclosed to you from records protected by federal confidentiality rules (<i>42 CFR part 2</i>). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). 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, except as provided at §§ 2.12(c)(5) and 2.65. DISTRIBUTION: □Client declined a copy of the signed release of informatio □ Client was given a copy of the signed release of information. Date:				

□ To agency/person from whom information is sought