PRAIRIE HARVEST MENTAL HEALTH

AUTHORIZATION TO DISCLOSE INFORMATION

930 North 3rd Street, Grand Forks, ND 58203-2408

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. Prairie Harvest Mental Health may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for enrollment in Prairie Harvest Mental Health programs.

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Social Security Number:		Date of Birth:
Street Address:	City **Grand Forks**:	State: **ND**	Zip Code:

CLIENT RELEASE AND SIGNATURE

1. **I Hereby Authorize:**			
Name of Person/Agency: **Prairie Harvest Mental Health**			
Street Address: **930 N 3rd St**	City: **Grand Forks**	State: **ND**	Zip Code: **58203-2408**
2. **To Release Information To and/or Receive Information From:**			
Street Address:	City:	State:	Zip Code:
3. The Following Information Is Requested: (Be Specific)			
4. The Information Identified Above Will Be Used For: (List Each Purpose)			
5. This Authorization to Disclose Information Remains in Effect Until: (Date)			
OR: (Specific Event Terminating Operation of the Release)			

CLIENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice of the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.

Signature of Client:	Date:
Signature of Parent/Guardian or Custodian (if needed and Relationship):	Date:
Signature of Witness (if needed):	Date:

☐ **CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part. 3. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.