2903 15th Street South
Moorhead, MN 56560

MENTAL HEALTH RELEASE OF INFORMATION FOR _____

Release To:

I hereby authorize Part 2 Program/Mental Health Department of CCRI, Inc. to provide _____ with protected health information relating to care and treatment rendered to me at or by CCRI, Inc.

- ☐ Functional Assessment
- ☐ Discharge Summary/Plan
- ☐ History and Physical
- ☐ Consults
- ☐ Treatment Plan
- ☐ Diagnosis/Diagnostic Assessment
- ☐ Case Plan/Progress Notes
- ☐ Medications/Dosage
- ☐ Other: _____

Purpose of Disclosure: _____

I authorize the release of the above-described information to occur by the following methods, designated by checkmark below:

- ☐ Verbally
- ☐ In-person conference
- ☐ Mailed or faxed medical record/correspondence

Obtain From:

I hereby authorize _____
to provide CCRI, Inc. with protected health information relating to care and treatment rendered to me at or by

- ☐ Psychiatric Assessment
- ☐ Functional Assessment
- ☐ Discharge Summary/Plan
- ☐ History and Physical
- ☐ Consults
- ☐ Neuropsychological/Psychological Testing
- ☐ Diagnosis/Diagnostic Assessment
- ☐ Case Plan/Progress Notes
- ☐ Medications/Dosage
- ☐ Treatment Plan
- ☐ Other: _____

Purpose of Disclosure: _____

I authorize the release of the above-described information to occur by the following methods, designated by checkmark below:

- ☐ Verbally
- ☐ In-person conference
- ☐ Mailed or faxed medical record/correspondence

This authorization remains in effect unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be in breach of confidentiality.

I understand that I need not sign this authorization in order to assure treatment.

I understand that I may inspect or request copies of any information disclosed under this authorization, as provided under applicable state and federal laws, and that I am entitled to a copy of this authorization form once I have signed it.

I understand that this authorization will expire on _____/_____/_____ or, if no date or event is specified, 12 months from the date signed below, and a photocopy shall be as effective as the original.

I understand that with the exception of Substance Use Disorder records and information, information disclosed pursuant to this Release may be re-disclosed by the recipient and may no longer be protected by state and federal regulations.

I understand that CCRI, Inc. has a Part 2 Program for purpose of 42 CFR Part 2. 42 CFR Part 2 prohibits unauthorized redisclosure of Substance Use Disorder information disclosed pursuant to this Release.

Initial: _____ I specifically authorize the release of Substance Use Disorder records. All records pertaining to Substance Use Disorder will not be released unless specifically authorized in writing.

Signature/Date _____

Client Name: _____

Date of Birth: _____

Social Security Number: _____