Consent for Release of Information

I, _____ Date of Birth: _____ Phone Number: _____

Address: _____

hereby authorize: Eckert Youth Homes; 1102 7th Avenue East Williston, North Dakota 58801, 701.572.7262, admissions@eckertyouth.com

to mutually exchange with:

Name of Person/Agency: _____ Relationship: _____

Address: _____

Email: _____ Phone Number: _____

the information specified below, as authorized by this consent.
Information to be released:

- ☐ Emergency Information
- ☐ Legal/Court Records (A)
- ☐ Communicable Disease Records (B)
- ☐ Mental Health Records (C)
- ☐ Treatment Plans
- ☐ Diagnosis
- ☐ Discharge Summaries
- ☐ Medical Records (D)
- ☐ Acknowledge of Presence in Treatment
- ☐ Substance Use Disorder Records (E)
- ☐ Peer Reviews
- ☐ Transition Meeting
- ☐ Progress/Provider Notes
- ☐ Treatment/Service Dates
- ☐ Family Sessions
- ☐ Drug Screen Results
- ☐ Assessments
- ☐ Treatment Recommendations
- ☐ Medication Records
- ☐ History/Physical Exams
- ☐ Other _____

Purpose of this release of information:

- ☐ Emergency Contact
- ☐ Care Coordination
- ☐ Referrals
- ☐ Financial Responsibility (F)
- ☐ Consultation & Collateral (G)
- ☐ Healthcare Providers (H)
- ☐ Individuals & entities as specified below (I)
- ☐ To Transfer Client Care
- ☐ Client Request
- ☐ Phone List
- ☐ Client Transport
- ☐ To Inform Family and/or Representative
- ☐ Admission & Treatment
- ☐ Admit & Discharge Planning
- ☐ Other _____

Disclosure Format: ☐ Paper/US Mail or Fax ☐ Email ☐ Telephonic ☐ Verbal ☐ Other Format

Descriptions:

A. Legal/Court Records: Includes but not limited to, Court Orders, Documents, Letters, & Department of Corrections-Parole/Probation. (This does NOT include for legal proceedings. Separate release is needed for legal proceedings.)

B. Communicable Disease Records HIV/Sexually Transmitted Disease (STD) as defined by law.

C. Mental Health Records: May include behavioral health evaluations, recommendations, progress, discharge and referral information and diagnosis, screenings, and peer reviews.

D. Medical Records: includes but not limited to Provider & Nursing: labs, procedures, examinations, diagnosis(es), orders, treatments, progress notes, medications, discharge summary & instructions.

E. Substance Use Disorder Records includes diagnosis information regarding substance use disorder: May include evaluations, recommendations, progress, discharge and referral information. **Eckert does not keep SUD Counseling Notes that are separate from the client record.**

F. Financial Responsibility: Insurance coverage, coverage eligibility determination, billing statements, & claims review.

G. Consultation & Collateral for: Provision of services, Coordination of Care, Treatment, Referrals, Discharge Planning, & Follow-up.

H. Healthcare Providers who are providing or have provided health care to the client; any individual or entity responsible for payment of programs or other providers charges; to healthcare providers or organizations accrediting or surveying the programs facility; Utilization review, quality assurance, or peer review; the program facilities business associates/consultants; and to the program facilities legal representatives and professional liability carriers.

I. Individuals & entities as specified by federal and state law and/or in the program facilities Notice of Privacy Practices.

Consent for Release of Information

SUBSTANCE USE DISORDER INFORMATION is protected under the federal confidentiality regulations governing Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and may not be used or disclosed without the written consent of the patient unless otherwise permitted by law.
In accordance with North Dakota law, disclosure of substance use disorder information requires:

- Age 14 years or older: minor's signature required
- Age 13 years or younger: minor and parent/guardian signatures required

Uses and disclosures authorized by this consent will be limited to the minimum information necessary to accomplish the intended purpose and to the extent the recipient needs the information to fulfill that purpose.

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 (42 C.F.R. Part 2). The federal rules prohibit you from using or disclosing this information to investigate or prosecute a patient with a substance use disorder, except as permitted by law, and from making any further disclosure unless expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2.

Patient Acknowledgment
I understand that my substance use disorder treatment information is protected by federal law, including 42 C.F.R. Part 2 and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164.

I understand that my health information, as specified on this form, will be disclosed pursuant to this authorization and that the recipient of the information may redisclose the information and it may no longer be protected under HIPAA. Federal law (42 C.F.R. Part 2), however, continues to protect the confidentiality of information that identifies me as having or having had a substance use disorder from unauthorized redisclosure.

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it, and that this consent will expire one (1) year from the date signed unless otherwise specified below.

Date, event, or condition upon which this consent expires: _____

I understand that I will not be denied treatment, payment, enrollment, or eligibility for benefits if I refuse to sign this authorization, except when disclosure is necessary for treatment, payment, or health care operations and permitted by law.

I understand that information may be shared verbally, electronically (including email or fax), or in writing unless I request otherwise.

I understand that I am entitled to receive a copy of this authorization after I sign it and that it has been explained to me in a language I understand.

I understand that I have the right to request a list of disclosures of my Part 2-protected information made with my consent during the three (3) years prior to the date of my request, consistent with 42 C.F.R. §2.25.

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