KAI SHIN
CLINIC.TREATMENT.LAB

PATIENT AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Kai Shin Treatment
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PATIENT INFORMATION	Patient Name:_____ DOB: _____ Previous Last Name(s): _____
TYPE OF RELEASE	□ Written-Mailed or Faxed □ Verbal
HEALTH INFORMATION RELEASE (select one or both)	□ I authorize Kai Shin Treatment to **RECEIVE** information **FROM:** □ I authorize Kai Shin Treatment to **RELEASE** information **TO:** NAME: _____ ADDRESS:_____ CITY: _____ STATE: _____ ZIP: _____ PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED (you may select more than one)	**DATES OF SERVICE(S) FROM: _____TO: _____ □ ALL DATES** □ ASSESSMENT/SUMMARIES □ TREATMENTPLANS/REVIEWS □ CHEMICAL HEALTH INFORMATION □ LAB RESULTS □ DISCHARGE SUMMARY □ DIAGNOSIS □ OTHER: _____
PURPOSE OF RELEASE **Fees may be charged based on MN State &Federal Regulations*	□ CONTINUATION OF CARE □ INSURANCE PAYMENT □ OTHER: _____ □ PERSONAL □ LEGAL □ INSURANCE □ Referral and Continuation of Care

ALL RECORDS PERTAINING TO MENTAL HEALTH/CHEMICAL DEPENDENCY/DRUG OR ALCOHOL ABUSE OR HIV RELATED ILLNESSES AND TREATMENT RECORDS WILL BE RELEASED UNLESS INDICATED HERE:
□ **DO NOT RELEASE RECORDS TO ANY OF THE PREVIOUSLY LISTED INFORMATION**

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 4 CFR Parts 160 & 164, Subparts A & E and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand the information to be released may include records related to behavioral and/or mental health care and/or alcohol and drug abuse treatment. This authorization may be revoked at any time except to the extent that Kai Shin Treatment has already acted in reliance on it. Kai Shin Treatment will not condition care on whether I sign the authorization. Information used/disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. It is understood that where federal laws and state laws relation to the court system apply, they should take precedence over any expiration or revocation expressed. I understand this realize with terminate in one year unless specified here:For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)

* Communications resulting from this authorization will reveal that I receive services at Kai Shin Treatment.
* Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records.

However, HIPAA requires Kai Shin Treatment to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.

* This authorization may be used by Kai Shin Treatment owned or managed programs upon transfer of my care to them.

** Information to be 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 consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient/Guardian Signature: Date

Staff Signature: Date: