

Professional. Compassionate. Dedicated.

#### INFORMED CONSENT AND AUTHORIZATION

Consent for Treatment I give my consent to the Human Development Center (HDC) providers and support staff

If I am signing as an authorized representative of the client, I am: (Circle one)	
Printed Name	
Signature Date	-
This authorization is valid for one year from the date of signature. I may revoke this co any future time upon written notice to HDC.	onsent and authorization at
I have been given the opportunity to discuss my concerns and questions about the privace or I may contact the HDC Privacy Officer at 1401 East First St., Duluth, MN 55805 or toll-	
I acknowledge I have received the HDC <b>NOTICE OF PRIVACY PRACTICES</b> that information will be handled in various situations. I understand that I can request a coppractices from HDC. I understand an electronic copy of the HDC NOTICE OF PRIVACY at https://www.humandevelopmentcenter.org/.	ov of the Notice of Privacy
<b>HDC Financial policies exist that:</b> A client is required to pay the applicable co-pay a each visit.	amount due at the time of
<u>Client Information</u> I have received the Client Information booklet informing me of HDC a client.	policies and my rights as
Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I under regulations of these programs shall apply. I may contact the Medicare Coordination of Be 999-1118 if I have questions.	rstand the laws, rules, and enefits Contractor at 1-800-
Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits, other sources for claims for my care originating from HDC to be paid directly to HDC. due for any services received that are not covered by insurance or grant funding.	or benefit payments from I agree to pay the balance
<b>Examples:</b> HDC providers from whom I accept services or treatment may share my i providers involved in my care. I understand that for various services HDC providers are function as a team and will share my information within that team in a confidential Consultation process between members of an HDC multidisciplinary team may incluabout a client. This case Consultation is good practice and helps to ensure high quality of	e required to or designed to manner. I understand the ude confidential discussion
Authorization for Disclosure of Protected Health Information (PHI) As explain Practices, I authorize disclosure of my protected health information for the purpose of H and Healthcare Operations. HDC may disclose my health information to and access other providers using a record locator service or patient information service of a health treatment unless I object by checking here:	IDC's Treatment, Payment, my health information from
to provide, coordinate, and/or manage behavioral health services for me.	Providence and outprovidence

\*Court Appointed guardian/conservator

\*Must provide documentation of guardianship, conservatorship, power of attorney for healthcare

\*Power of Attorney for Healthcare

Client Name\_\_\_\_\_

Client#

Staff must document any refusal to sign

\*Parent of a minor

HDC located at:	
<ul> <li>✓ All HDC Locations (See Primary Agency Address below)</li> <li>☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)</li> </ul>	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
810 E. 4th Street, Duluth, MN 55805	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880 ☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 5572
, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) 🗵 release to 🗵 obtain from	⊠ verbal exchange
Agency or Individual: St. Louis County PHHS	
Address:	
☐ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
$oxed{oxed}$ Continuing Care/Treatment Planning $oxed{\Box}$ Social Services Involves	ment   Personal Records   Legal
☐ Other Purpose (Specify):	
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service note will be	released.
The fellows with the state of t	
The following information may be disclosed: (Pertinent, minimum ned   Medical History/History and Physical Exam   Medi	
— ···	cation Records 🛮 Discharge Summary ess Notes 🔻 Treatment Plan
<u> </u>	gency Room Records 🛮 Lab Results
	ostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
RESTRICTION: State and federal law protect the following information	ONLY indicate if you DO NOT authorize for its release
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	is other indicate if you bo not authorize for its release.
This push arimation facts for an arrangement of the state	
<ul> <li>This authorization lasts for one year after the signed date unless you enter a different</li> <li>This authorization may be canceled in writing at any time. A cancellation will not char</li> </ul>	expiration date here:
Privacy Practice describes how to cancel (revoke) this authorization.	
<ul> <li>HDC may not place conditions on my treatment, payment, or operations based on whe</li> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>	ther or not I sign this authorization.
<ul> <li>HDC records may include records from other organizations that were used for my treat</li> </ul>	ment.
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization v</li> </ul>	who receives your records under this authorization, and that information may
not be covered by state and federal privacy protections after it is released. By signing th disclosure by the recipient.	is authorization, you release HDC from any and all liability resulting from a re-
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure by</li> </ul>	42 CFR, Part II. The Federal rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitted by the wri CFR, Part II.	tten consent of the person to whom it pertains or otherwise permitted by 42
<ul> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may supervising inspection of medical/dental records.</li> </ul>	
<ul> <li>Your signature indicates that you have read and understand this form and authorize re</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	ease of your information as described above.
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
	lient Medical Record Number:

HDC located at:  ☑ All HDC Locations (See Primary Agency Address below)	T 225 44th A	The Mark and AMILECON
1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)		Two Harbors, MN 55616 treet, Suite #100, Superior, WI 54880
		Cloquet, MN 55720
120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Cariton County	ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Namas		
Name:Last, First, MI		Name:
Last, First, IVII	Birth dat	e:
I authorize HDC to: (check all that apply) $oxtimes$ release to $oxtimes$ obtain from	⊠ verbal exchang	e
Agency or Individual: Center of Alcohol & Drug Treatment (C	ADT)	
Address:		
☐ Pick-up (Phone Number):		☑ Mail
Purpose of this disclosure:  ☐ Continuing Care/Treatment Planning ☐ Social Services Involven ☐ Other Purpose (Specify):	nent 🗌 Person	al Records   Legal
Indicate Data(a) of Courts of seconds to be also		
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be r		
in the specific dates are listed, only the most recent service note will be r	eieuseu.	
The following information may be disclosed: (Pertinent, minimum nec	essary to accomplis	h the stated purpose)
	ation Records	Discharge Summary
and the second s	ess Notes	☑ Treatment Plan
	gency Room Record	s 🔯 Lab Results sych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	DSGC ASSESSMEIL (F.	syon. Evalyminal and/or comp. Eval.
RESTRICTION: State and federal law protect the following information	. <u>ONLY</u> indicate if y	ou <u>DO NOT</u> authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health		
This authorization lasts for one year after the signed date <u>unless</u> you enter a different of	voiration date here	
. This authorization may be canceled in writing at any time. A cancellation will not chan	ge releases that have be	en honored before the cancellation. HDC's Notice of
Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations based on whe	her or not I sign this aut	harization
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>		serzaum.
<ul> <li>HDC records may include records from other organizations that were used for my treat</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization w</li> </ul>	nent. bo receives vour record	e under this authorization, and that information may
not be covered by state and federal privacy protections after it is released. By signing thi	authorization, you rele	ase HDC from any and all liability resulting from a re-
disclosure by the recipient.  • Chemical dependency/substance abuse records are protected from re-disclosure by	42 CER Part II The End	lard rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitted by the writ	ten consent of the pers	on to whom it pertains or otherwise permitted by 42
CFR, Part II.  In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may	he required to you a f	
supervising inspection of medical/dental records.		
<ul> <li>Your signature indicates that you have read and understand this form and authorize rel</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	ease of your information	as described above.
Signature of Client, Parent, or Legal Representative:		Date:
FOR OFFICE USE ONLY		
Provider Name: ACT CI	ient Medical Record	J Number:

HDC located at:	77 AAR 44 M 11 1 AAR 5545	
△ All HDC Locations (See Primary Agency Address below)  □ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616 ☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880	
<ul> <li>✓ Street, Duluth, MN 55805 (Primary Agency Address)</li> <li>✓ 810 E. 4<sup>th</sup> Street, Duluth, MN 55805</li> </ul>	☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720	
☐ 120 W. 2nd Street, Duluth, MN 55802	☐ Cariton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 557	720
Name:	Previous Name:	-
Last, First, MI	Birth date:	-
I authorize HDC to: (check all that apply) $\  \  \  \  \  \  \  \  \  \  \  \  \ $	☑ verbal exchange	
Agency or Individual: Genoa Pharmacy		_
Address:		_
		_
☑ Pick-up (Phone Number):	─────────────────────────────────────	
Purpose of this disclosure:		
☐ Continuing Care/Treatment Planning ☐ Social Services Involven ☐ Other Purpose (Specify):	nent   Personal Records   Legal	_
Indicate Date(s) of Service of records to be released:		_
If no specific dates are listed, only the most recent service note will be r	eleased.	
The following information may be disclosed: (Pertinent, minimum nec	essary to accomplish the stated purpose)	
	cation Records \overline{\times} Discharge Summary	
	ess Notes 🖾 Treatment Plan	
	gency Room Records 🗵 Lab Results	
	ostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	
☐ Other (Specify Record Type(s):		
RESTRICTION: State and federal law protect the following information	. ONLY indicate if you DO NOT authorize for its release.	
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health		
• This authorization lasts for one year after the signed date <u>unless</u> you enter a different of		
<ul> <li>This authorization may be canceled in writing at any time. A cancellation will not char Privacy Practice describes how to cancel (revoke) this authorization.</li> </ul>	ge releases that have been honored before the cancellation. HDC's Notice of	of
<ul> <li>HDC may not place conditions on my treatment, payment, or operations based on whe</li> </ul>	ther or not I sign this authorization.	
• A photocopy/fax of this authorization will be treated in the same way as an original.	•	
<ul> <li>HDC records may include records from other organizations that were used for my treat</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization v</li> </ul>		w
not be covered by state and federal privacy protections after it is released. By signing this	•	•
disclosure by the recipient.		
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure by disclosure of this information unless further disclosure expressly is permitted by the writer part in</li> </ul>		
CFR, Part II.  • In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may supervising inspection of medical/dental records.	be required to pay a fee for retrieval and photocopying of records and/c	or
<ul> <li>Your signature indicates that you have read and understand this form and authorize re</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	ease of your information as described above.	
Signature of Client, Parent, or Legal Representative:	Date:	
FOR OFFICE USE ONLY		_
Provider Name: ACT C	lient Medical Record Number:	

HDC located at:	
All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
810 E. 4th Street, Duluth, MN 55805	40 11th Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	⊠ verbal exchange
Agency or Individual: Social Security Administration (SSA)	
Address:	
	l:
☑ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:  ☐ Continuing Care/Treatment Planning ☐ Social Services Involved	ment   Personal Records   Legal
☐ Other Purpose (Specify):	
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be The following information may be disclosed: (Pertinent, minimum nec	
	cation Records
Parties and the second	ress Notes   Treatment Plan
	gency Room Records    Lab Results
	nostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
DECEDICATION. Contract forders I have been stated following in factors	
RESTRICTION: State and federal law protect the following information:  ☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	a. ONLY indicate if you DO NOT authorize for its release.
<ul> <li>This authorization lasts for one year after the signed date <u>unless</u> you enter a different</li> <li>This authorization may be canceled in writing at any time. A cancellation will not char Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>HDC may not place conditions on my treatment, payment, or operations based on wheto the photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treat</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization on the covered by state and federal privacy protections after it is released. By signing the disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by disclosure of this information unless further disclosure expressly is permitted by the writer.</li> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize re</li> <li>You have the right to a copy of this signed authorization.</li> </ul> Signature of Client, Parent, or Legal Representative:	inge releases that have been honored before the cancellation. HDC's Notice of other or not I sign this authorization.  It ment.  Who receives your records under this authorization, and that information may is authorization, you release HDC from any and all liability resulting from a re-  42 CFR, Part II. The Federal rules prohibit you from making any further re- tten consent of the person to whom it pertains or otherwise permitted by 42  The better the person to be required to pay a fee for retrieval and photocopying of records and/or
FOR OFFICE USE ONLY	
Provider Name: ACT	lient Medical Record Number:

HDC located at:	
All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
⊠ 810 E. 4 <sup>th</sup> Street, Duluth, MN 55805	☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
l authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	ı ⊠ verbal exchange
Agency or Individual: Essentia Health	
Address:	
	]:
☑ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
<ul><li>☑ Continuing Care/Treatment Planning</li><li>☐ Social Services Involve</li><li>☐ Other Purpose (Specify):</li></ul>	ement   Personal Records   Legal
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service note will be	released.
The following information may be disclosed: (Pertinent, minimum ne	cessary to accomplish the stated purpose)
MANY	lication Records
☐ Chemical Dependency/Substance Use Notes ☐ Prog	ress Notes   Treatment Plan
☑ Social Services Reports/Interventions ☑ Eme	rgency Room Records ⊠ Lab Results
	nostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
RESTRICTION: State and federal law protect the following information	on. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	
• This authorization lasts for one year after the signed date unless you enter a different	expiration date here:
This authorization may be canceled in writing at any time. A cancellation will not character a control of the control of	inge releases that have been honored before the cancellation. HDC's Notice of
Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations based on whether the properties of	ether or not I sign this authorization
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>	
HDC records may include records from other organizations that were used for my tree     HDC connect prevent to disclosure of your information but the general or a record in the connect prevent of the prevent of	
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization not be covered by state and federal privacy protections after it is released. By signing t</li> </ul>	who receives your records under this authorization, and that information may his authorization, you release HDC from any and all liability resulting from a re-
disclosure by the recipient.	
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure b disclosure of this information unless further disclosure expressly is permitted by the w CFR, Part II.</li> </ul>	y 42 CFR, Part II. The Federal rules prohibit you from making any further re- ritten consent of the person to whom it pertains or otherwise permitted by 42
<ul> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I me supervising inspection of medical/dental records.</li> </ul>	
<ul> <li>Your signature indicates that you have read and understand this form and authorize r</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	elease of your information as described above.
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
Provider Name: ACT	Client Medical Record Number:

Last, First, MI   Birth date:	HDC located at:	
8810 £4% Street, Duluth, MN 55802		· · · · · · · · · · · · · · · · · · ·
120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802		
Name:		
Last, First, MI   Birth date:	L3 120 W. 2nd Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MIN 557
Last, First, Mi   Birth date:	Name:	Previous Name:
Address:  Method of Disclosure:     Fax:	Last, First, MI	Birth date:
Method of Disclosure:	l authorize HDC to: (check all that apply) 🗵 release to 🗵 obtain from	☑ verbal exchange
Method of Disclosure:    Pick-up (Phone Number):	Agency or Individual: St. Luke's Hospital/Clinics	
Purpose of this disclosure:  © Continuing Care/Treatment Planning	Address:	
Purpose of this disclosure:  ② Continuing Care/Treatment Planning		il:
© Continuing Care/Treatment Planning	☑ Pick-up (Phone Number):	⊠ Mail
© Continuing Care/Treatment Planning	Purpose of this disclosure:	
If no specific dates are listed, only the most recent service note will be released.  The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)  Medical History/History and Physical Exam  Medical History/History and Physical Exam  Medication Records  Treatment Plan  Social Services Reports/Interventions  Social Services Reports/Interventions  Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.  Chemical Dependency/Substance Use Notes  Progress Notes  Treatment Plan  Social Services Reports/Interventions  Emergency Room Records  Lab Results  Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.  Other (Specify Record Type(s):  MESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.  Substance Abuse  HIV Test Results  Mental Health  This authorization lasts for one year after the signed date unless you enter a different expiration date here:  This authorization may be cancelled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  Chemical dependency/Substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthed disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted is CFR, Part II.  In compliance with MN St	oximes Continuing Care/Treatment Planning $oximes$ Social Services Involve	ment   Personal Records   Legal
If no specific dates are listed, only the most recent service note will be released.  The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)  Medical History/History and Physical Exam  Medical History/History and Physical Exam  Medication Records  Treatment Plan  Social Services Reports/Interventions  Social Services Reports/Interventions  Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.  Chemical Dependency/Substance Use Notes  Progress Notes  Treatment Plan  Social Services Reports/Interventions  Emergency Room Records  Lab Results  Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.  Other (Specify Record Type(s):  MESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.  Substance Abuse  HIV Test Results  Mental Health  This authorization lasts for one year after the signed date unless you enter a different expiration date here:  This authorization may be cancelled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  Chemical dependency/Substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthed disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted is CFR, Part II.  In compliance with MN St	Indicate Datale) of Service of records to be released.	
The following information may be disclosed: (Pertinent, minimum necessary to accomplish the stated purpose)  Medical History/History and Physical Exam Medication Records Discharge Summary Chemical Dependency/Substance Use Notes Progress Notes Discharge Summary Chemical Dependency/Substance Use Notes Discharge Records Chemical Dependency/Substance Abuse Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval. Diagnostic Assessment/Psych. Eval/Initial and/or Comp. E		relensed
Medical History/History and Physical Exam	g the emission and the tree tree tree tree tree tree tree	10100000
School Reports: Grades, Behaviors, IEP Singular Indicate if you DO NOT authorize for its release.  □ Chemical Dependency/Substance Use Notes Singular Indicate if you DO NOT authorize for its release.  □ Cher (Specify Record Type(s):  RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.  □ Substance Abuse □ HIV Test Results □ Mental Health  • This authorization lasts for one year after the signed date unless you enter a different expiration date here:  • This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  • HDC cannot prevent re-disclosure of your informations that were used for my treatment.  • HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information to be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  • Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthe disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the uniformation and photocopying of records ans supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • You have the right to a copy of this signed authorization.  FOR OFFICE USE ONLY		
Social Services Reports/Interventions	<u> </u>	,
School Reports: Grades, Behaviors, IEP		
□ Other (Specify Record Type(s):  RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.  □ Substance Abuse □ HIV Test Results □ Mental Health  • This authorization lasts for one year after the signed date <u>unless</u> you enter a different expiration date here:  • This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  • HDC records may include records from other organizations that were used for my treatment.  • HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  • Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthed disclosure of this information unless further disclosure expressify is permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • Your signature indicates that you have read		• • • • • • • • • • • • • • • • • • • •
RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.  Substance Abuse	•	
□ Substance Abuse □ HIV Test Results □ Mental Health  • This authorization lasts for one year after the signed date <u>unless</u> you enter a different expiration date here:  • This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Notice Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  • A photocopy/fax of this authorization will be treated in the same way as an original.  • HDC records may include records from other organizations that were used for my treatment.  • HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  • Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthed disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the written compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  • FOR OFFICE USE ONLY	☐ Other (Specify Record Type(s):	
□ Substance Abuse □ HIV Test Results □ Mental Health  • This authorization lasts for one year after the signed date <u>unless</u> you enter a different expiration date here:  • This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Notice Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  • A photocopy/fax of this authorization will be treated in the same way as an original.  • HDC records may include records from other organizations that were used for my treatment.  • HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  • Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthed disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the written compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  • FOR OFFICE USE ONLY	RESTRICTION: State and federal law protect the following information	n. ONLY indicate if you DO NOT authorize for its release.
<ul> <li>This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.</li> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treatment.</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthe disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the recipient.</li> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize release of your information as described above.</li> <li>You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul> Date: FOR OFFICE USE ONLY	<del></del>	
<ul> <li>This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Noti Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.</li> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treatment.</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any furthe disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the person to whom it pertains or otherwise permitted by the person to make the person to whom it pertains or otherwise permitted by the person to make the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or otherwise permitted by the uniformation of the person to whom it pertains or</li></ul>	- This authorization lasts for one was after the signed date unless you enter a different	
Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.  A photocopy/fax of this authorization will be treated in the same way as an original.  HDC records may include records from other organizations that were used for my treatment.  HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted CFR, Part II.  In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  Your signature indicates that you have read and understand this form and authorize release of your information as described above.  You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  Date:  FOR OFFICE USE ONLY	<ul> <li>This authorization may be canceled in writing at any time. A cancellation will not cha</li> </ul>	
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treatment.</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by CFR, Part II.</li> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize release of your information as described above.</li> <li>You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul> Date: FOR OFFICE USE ONLY	Privacy Practice describes how to cancel (revoke) this authorization.	
<ul> <li>HDC records may include records from other organizations that were used for my treatment.</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by CFR, Part II.</li> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize release of your information as described above.</li> <li>You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul> Date: FOR OFFICE USE ONLY	HDC may not place conditions on my treatment, payment, or operations based on when A the transport of this parth of particular will be treated in the come way as an original and the come way as a province of the come way are a province of the come way as a province of the come way are a province of the come way as a province of the come way	ether or not I sign this authorization.
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by CFR, Part II.</li> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize release of your information as described above.</li> <li>You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul> Date: FOR OFFICE USE ONLY	<ul> <li>A photocopy/rax of this authorization will be dealed in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treat</li> </ul>	atment.
not be covered by state and federal privacy protections after it is released. By signing this authorization, you release HDC from any and all liability resulting from disclosure by the recipient.  Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  Your signature indicates that you have read and understand this form and authorize release of your information as described above.  You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  Date:  FOR OFFICE USE ONLY	<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization</li> </ul>	who receives your records under this authorization, and that information ma
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to whom it pertains or otherwise permitted by the written consent of the person to w</li></ul>	not be covered by state and federal privacy protections after it is released. By signing ti	nis authorization, you release HDC from any and all liability resulting from a re
disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by CFR, Part II.  In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records an supervising inspection of medical/dental records.  Your signature indicates that you have read and understand this form and authorize release of your information as described above.  You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  Date:  FOR OFFICE USE ONLY		A2 CER Part II. The Federal rules prohibit you from making any further re
supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and authorize release of your information as described above.  • You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  Date:	disclosure of this information unless further disclosure expressly is permitted by the wr CFR, Part II.	ritten consent of the person to whom it pertains or otherwise permitted by 4:
You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:  FOR OFFICE USE ONLY  Date:	supervising inspection of medical/dental records.	
FOR OFFICE USE ONLY	<ul> <li>You have the right to a copy of this signed authorization.</li> </ul>	sidade of your insufficient as described assets.
	Signature of Client, Parent, or Legal Representative:	Date:
	FOR OFFICE USE ONLY	
Provider Name: ACI Client Medical Record Number:		Client Medical Record Number:

☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
40 11th Street, Cloquet, MN 55720
☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 5572
Previous Name:
Birth date:
☑ verbal exchange
[:
⊠ Mail
ment 🗆 Personal Records 🖂 Legal
·
released.
releuseu.
cessary to accomplish the stated purpose)
ication Records 🗵 Discharge Summary
ress Notes 🖾 Treatment Plan
gency Room Records 🔀 Lab Results
nostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
n. ONLY indicate if you DO NOT authorize for its release.
Manage if you bo 100 a detroited for to record
expiration date here:
ige   cleases that have been noticed before the concentions, tipe 3 notice of
ether or not I sign this authorization.
tment.
who receives your records under this authorization, and that information may
is authorization, you release HDC from any and all liability resulting from a re-
AT CER Book II The Endand value exchibit way from matrice and finish as
42 CFR, Part II. The Federal rules prohibit you from making any further re- itten consent of the person to whom it pertains or otherwise permitted by 42
y be required to pay a fee for retrieval and photocopying of records and/or
elease of your information as described above.
Date:
Client Medical Record Number:

HDC located at:	
All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
<ul> <li>✓ 810 E. 4<sup>th</sup> Street, Duluth, MN 55805</li> <li>✓ 120 W. 2<sup>nd</sup> Street, Duluth, MN 55802</li> </ul>	☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720 ☐ Cariton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
120 W. 2 30 eet, Duiddi, Will 33002	Canton County Act, 1100 Ave. 5, June 200, Gloques, Mit 35720
Name:	Previous Name:
Last, First, MI	Birth date:
1 authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	n 🗵 verbal exchange
Agency or Individual: Thrive Behavior Network (Birch Tree C	Center)
Address:	
	nil:
☐ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:  ☑ Continuing Care/Treatment Planning ☐ Social Services Involve ☐ Other Purpose (Specify):	ement   Personal Records   Legal
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be	released.
The following information may be disclosed: (Pertinent, minimum ne	·
	dication Records 🗵 Discharge Summary
	gress Notes   Treatment Plan
- · · · · · · · · · · · · · · · · · · ·	ergency Room Records
The state of the s	mostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
RESTRICTION: State and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the following information of the state and federal law protect the state and federal law p	on. <u>ONLY</u> indicate if you <u>DO NOT</u> authorize for its release.
<ul> <li>This authorization lasts for one year after the signed date <u>unless</u> you enter a differen</li> <li>This authorization may be canceled in writing at any time. A cancellation will not che Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>HDC may not place conditions on my treatment, payment, or operations based on will be treated in the same way as an original.</li> </ul>	ange releases that have been honored before the cancellation. HDC's Notice of
<ul> <li>HDC records may include records from other organizations that were used for my tre</li> <li>HDC cannot prevent re-disclosure of your information by the person or organization not be covered by state and federal privacy protections after it is released. By signing disclosure by the recipient.</li> </ul>	who receives your records under this authorization, and that information may
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure bedisclosure of this information unless further disclosure expressly is permitted by the w CFR, Part II.</li> </ul>	
<ul> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I m supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize</li> </ul>	
<ul> <li>You have the right to a copy of this signed authorization.</li> </ul>	Date:
Signature of Client, Parent, or Legal Representative:	Vac.
FOR OFFICE USE ONLY Provider Name: ACT	Client Medical Record Number:
Fronce (Bane, Act	CICITE SECURCIO INCOCCA ESCIENCE

HDC located at:	
☑ All HDC Locations (See Primary Agency Address below)	325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1401 E. 1 <sup>st</sup> Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
⊠ 810 E. 4 <sup>th</sup> Street, Duluth, MN 55805	40 11th Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 5572
Name:	Previous Name:
Last, First, Mi	Birth date:
I authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	ı ⊠ verbal exchange
Agency or Individual: Prairie St. John's (ND)	
Address:	
	il:
☑ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
☑ Continuing Care/Treatment Planning ☐ Social Services Involve	ment
☐ Other Purpose (Specify):	
Indicate Data(a) of Coming of vegetals to be unlessed.	
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be	released
if no specific dutes are used, only the most recent service note will be	, country
The following information may be disclosed: (Pertinent, minimum ne	
	lication Records
· · · · · · · · · · · · · · · · · · ·	ress Notes   Treatment Plan
•	rgency Room Records 🗵 Lab Results
•	nostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
RESTRICTION: State and federal law protect the following information	on. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	
• This authorization lasts for one year after the signed date <u>unless</u> you enter a different	expiration date here:
• This authorization may be canceled in writing at any time. A cancellation will not cha	
Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on whether the payment is the payment of the payment	cothar ar not laign this suth arientian
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>	settlet of not i sign this auditorization.
• HDC records may include records from other organizations that were used for my tre	
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization not be covered by state and federal privacy protections after it is released. By signing t</li> </ul>	
disclosure by the recipient.	ins authorization, you release ribe note any and an additive resulting from a re
• Chemical dependency/substance abuse records are protected from re-disclosure b	
disclosure of this information unless further disclosure expressly is permitted by the w CFR, Part II.	ritten consent of the person to whom it pertains or otherwise permitted by 42
<ul> <li>in compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I m supervising inspection of medical/dental records.</li> </ul>	ay be required to pay a fee for retrieval and photocopying of records and/o
<ul> <li>Your signature indicates that you have read and understand this form and authorize r</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	elease of your information as described above.
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
	Client Medical Record Number:
	E

HDC located at:	
☑ All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address	s) 🔲 1500 N. 34th Street, Suite #100, Superior, WI 54880
810 E. 4 <sup>th</sup> Street, Duluth, MN 55805	40 11th Street, Cloquet, MN 55720
120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) ⊠ release to ⊠ of	btain from 🗵 verbal exchange
Agency or Individual: Representative payee:	
Address:	
Method of Disclosure: ⊠ Fax:	⊠ Email:
☐ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
☑ Continuing Care/Treatment Planning ☐ Social Service	es involvement
☐ Other Purpose (Specify):	
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service no	ote will be released.
The following information may be disclosed: (Pertinent, mi	inimum necessary to accomplish the stated nurnece)
✓ Medical History/History and Physical Exam	Medication Records
☐ Chemical Dependency/Substance Use Notes	☑ Progress Notes ☑ Treatment Plan
☑ Social Services Reports/Interventions	☐ Emergency Room Records ☐ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☑ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☑ Other (Specify Record Type(s): Payee services/needs	= 0.000.000.000.000.000.000.000.000.000.
	information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Menta	ai Health
This authorization lasts for one year after the signed date <u>unless</u> you enter	er a different expiration date here:
· This authorization may be canceled in writing at any time. A cancellation	will not change releases that have been honored before the cancellation. HDC's Notice of
Privacy Practice describes how to cancel (revoke) this authorization.  HDC may not place conditions on my treatment, payment, or operations	hazad an whathay ar not being this puth wingtion
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as:</li> </ul>	
<ul> <li>HDC records may include records from other organizations that were use</li> </ul>	
HDC cannot prevent re-disclosure of your information by the person or on the covered by chats and fodom and proventions of the it is released.	organization who receives your records under this authorization, and that information may
disclosure by the recipient.	. By signing this authorization, you release HDC from any and all liability resulting from a re-
· Chemical dependency/substance abuse records are protected from re-	disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitt CFR, Part II.	ted by the written consent of the person to whom it pertains or otherwise permitted by 42
<ul> <li>In compliance with MN Statute 144.292 and WI Administrative Code H supervising inspection of medical/dental records,</li> </ul>	IFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or
<ul> <li>Your signature indicates that you have read and understand this form and</li> </ul>	d authorize release of your information as described above.
<ul> <li>You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul>	Date:
EOD OFFICE HEE ONLY	
FOR OFFICE USE ONLY Provider Name: ACT	Client Medical Record Number:
	WITCH IT WITCH STANDING THE THE TOTAL TOTA

HDC located at:	
All HDC Locations (See Primary Agency Address below)	325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)  ⊠ 810 E. 4th Street, Duluth, MN 55805	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
120 W. 2nd Street, Duluth, MN 55802	<ul> <li>40 11<sup>th</sup> Street, Cloquet, MN 55720</li> <li>Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 5572</li> </ul>
a 220 W. 2 Street, Daidely Will 33002	E Canton County ACT, 1105 Ave. B, Suite 200, Cloquet, Will 3572
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) ☒ release to ☒ obtain f	rom 🛮 verbal exchange
Agency or Individual: Housing & Redevelopment Authori	ty (HRA)
Address:	
	Email:
☐ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
<ul><li>☑ Continuing Care/Treatment Planning</li><li>☐ Social Services Invo</li><li>☐ Other Purpose (Specify):</li></ul>	olvement
Indicate Parto(s) of Coming of versuals to be unforced.	
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will	l be released.
The following information may be disclosed: (Pertinent, minimum	
	Medication Records  ☐ Discharge Summary
	Progress Notes   Treatment Plan
	Emergency Room Records 🗵 Lab Results
	Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☑ Other (Specify Record Type(s): Housing	
RESTRICTION: State and federal law protect the following inform	ation. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Heal	th
<ul> <li>This authorization lasts for one year after the signed date unless you enter a diffe</li> </ul>	erent expiration date here:
· This authorization may be canceled in writing at any time. A cancellation will not	t change releases that have been honored before the cancellation. HDC's Notice of
Privacy Practice describes how to cancel (revoke) this authorization.	
<ul> <li>HDC may not place conditions on my treatment, payment, or operations based or</li> <li>A photocopy/fax of this authorization will be treated in the same way as an origin</li> </ul>	n whether or not I sign this authorization.
HDC records may include records from other organizations that were used for my	/ treatment.
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organiza</li> </ul>	tion who receives your records under this authorization, and that information may
not be covered by state and federal privacy protections after it is released. By signi disclosure by the recipient.	ing this authorization, you release HDC from any and all liability resulting from a re-
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosus</li> </ul>	re by 42 CFR. Part II. The Federal rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitted by the CFR, Part II.	ne written consent of the person to whom it pertains or otherwise permitted by 42
<ul> <li>In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, supervising inspection of medical/dental records.</li> </ul>	
<ul> <li>Your signature indicates that you have read and understand this form and author</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	ize release of your information as described above.
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
Provider Name: ACT	Client Medical Record Number:

HDC located at:  ☑ All HDC Locations (See Primary Agency Address below)  ☐ 1401 E. 1 <sup>st</sup> Street, Duluth, MN 55805 (Primary Agency Address)  ☑ 810 E. 4 <sup>th</sup> Street, Duluth, MN 55805  ☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616 ☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880 ☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720 ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:Last, First, MI	Previous Name:
I authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	n 🛮 verbal exchange
Agency or Individual: Landlord:	
Address:	
Method of Disclosure: ⊠ Fax: ⊠ Ema	ail:
⊠ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:  ☑ Continuing Care/Treatment Planning ☐ Social Services Involve ☐ Other Purpose (Specify):	ement   Personal Records   Legal
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be	e released.
The following information may be disclosed: (Pertinent, minimum na	ecessary to accomplish the stated purpose)
- · · · · · · · · · · · · · · · · · · ·	dication Records 🛮 Discharge Summary
	gress Notes   Treatment Plan
•	ergency Room Records 🗵 Lab Results
☐ School Reports: Grades, Behaviors, IEP ☐ Diag	gnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s): Housing	
RESTRICTION: State and federal law protect the following informati	ion. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	
<ul> <li>This authorization lasts for one year after the signed date <u>unless</u> you enter a different this authorization may be canceled in writing at any time. A cancellation will not of Privacy Practice describes how to cancel (revoke) this authorization.</li> <li>HDC may not place conditions on my treatment, payment, or operations based on we A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>HDC records may include records from other organizations that were used for my treatment of the covered by state and federal privacy protections after it is released. By signing disclosure by the recipient.</li> <li>Chemical dependency/substance abuse records are protected from re-disclosure disclosure of this information unless further disclosure expressly is permitted by the vector.</li> <li>Lin compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I in supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize You have the right to a copy of this signed authorization.</li> <li>Signature of Client, Parent, or Legal Representative:</li> </ul>	hange releases that have been honored before the cancellation. HDC's Notice of whether or not I sign this authorization.  eatment.  In who receives your records under this authorization, and that information may this authorization, you release HDC from any and all liability resulting from a reby 42 CFR, Part II. The Federal rules prohibit you from making any further rewritten consent of the person to whom it pertains or otherwise permitted by 42 may be required to pay a fee for retrieval and photocopying of records and/or
FOR OFFICE USE ONLY	A A A A A A A A A A A A A A A A A A A
Provider Name: ACT	Client Medical Record Number:

HDC located at:	Car 14th Ave. True Herbert MAN FES16
☑ All HDC Locations (See Primary Agency Address below)     ☐ 1401 E. 1# Street, Duluth, MN 55805 (Primary Agency Address)	<ul> <li>325 11<sup>th</sup> Ave., Two Harbors, MN 55616</li> <li>1500 N. 34<sup>th</sup> Street, Suite #100, Superior, WI 54880</li> </ul>
810 E. 4th Street, Duluth, MN 55805	☐ 40 11 <sup>th</sup> Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) 🛮 release to 🖾 obtain from	om 🗵 verbal exchange
Agency or Individual: Employment:	
Address:	
	mail:
⊠ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
☑ Continuing Care/Treatment Planning ☐ Social Services Involution ☐ Other Purpose (Specify):	lvement   Personal Records   Legal
Indicate Date(s) of Service of records to be released:  If no specific dates are listed, only the most recent service note will be	be released.
The state of the s	**
The following information may be disclosed: (Pertinent, minimum in Modical History/History and Physical Even	necessary to accomplish the stated purpose) edication Records
	regress Notes   Mark Treatment Plan
	nergency Room Records   Lab Results
- · · · · · · · · · · · · · · · · · · ·	agnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☑ Other (Specify Record Type(s): Employment services/needs	
RESTRICTION: State and federal law protect the following information of the state o	
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	n
This authorization lasts for one year after the signed date <u>unless</u> you enter a different the unless	ent expiration date here:
. This authorization may be canceled in writing at any time. A cancellation will not o	
Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on the place conditions of the place conditions on the place conditions of	whether or not I sign this authorization
• A photocopy/fax of this authorization will be treated in the same way as an original	d.
HDC records may include records from other organizations that were used for my to HDC connect provide a disclosure of countries to the provide the provide and the provide the provide to the provide the pro	
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization of be covered by state and federal privacy protections after it is released. By signing</li> </ul>	
disclosure by the recipient.	2 min against 12 min 12
Chemical dependency/substance abuse records are protected from re-disclosure disclosure of this information unless further disclosure approach is normitted by the	
disclosure of this information unless further disclosure expressly is permitted by the CFR, Part II.	e written consent of the person to whom it pertains or otherwise permitted by 42
• In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I supervising inspection of medical/dental records.	
<ul> <li>Your signature indicates that you have read and understand this form and authorize</li> <li>You have the right to a copy of this signed authorization.</li> </ul>	e release of your information as described above.
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
Provider Name: ACT	Client Medical Record Number:

MDC located at:  Mail HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
<ul> <li>■ 810 E. 4<sup>th</sup> Street, Duluth, MN 55805</li> <li>□ 120 W. 2<sup>nd</sup> Street, Duluth, MN 55802</li> </ul>	40 11th Street, Cloquet, MN 55720
120 W. 2 Street, Duitti, IVIN 53802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:Last, First, MI	Previous Name:
Last, First, 1911	off ut date:
I authorize HDC to: (check all that apply) $oxtimes$ release to $oxtimes$ obtain from	☑ verbal exchange
Agency or Individual: Family/Friend:	
Address:	
☑ Pick-up (Phone Number):	⊠ Mail
Purpose of this disclosure:	
☐ Continuing Care/Treatment Planning ☐ Social Services Involver☐ Other Purpose (Specify):	ment   Personal Records   Legal
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service note will be r	eleased.
The following information was he disclosed. Bartinent minimum no	
The following information may be disclosed: (Pertinent, minimum nec  ☐ Medical History/History and Physical Exam  ☐ Medical History/History	cation Records
· · · · · · · · · · · · · · · · · · ·	ess Notes
•	gency Room Records   Lab Results
<u></u>	tostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☑ Other (Specify Record Type(s): In case of Emergency (ICE)	ostorosessinengrayon evay maan anay or compressing
RESTRICTION: State and federal law protect the following information	1. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	
• This authorization lasts for one year after the signed date <u>unless</u> you enter a different of	expiration date here:
. This authorization may be canceled in writing at any time. A cancellation will not char	
Privacy Practice describes how to cancel (revoke) this authorization.	of the above above and a second to
<ul> <li>HDC may not place conditions on my treatment, payment, or operations based on whe</li> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>	ther or not I sign this authorization.
<ul> <li>HDC records may include records from other organizations that were used for my treat</li> </ul>	
HDC cannot prevent re-disclosure of your information by the person or organization was a state of the control of the cont	the receives your records under this authorization, and that information may
not be covered by state and federal privacy protections after it is released. By signing this disclosure by the recipient.	is authorization, you release HDC from any and all liability resulting from a re-
<ul> <li>Chemical dependency/substance abuse records are protected from re-disclosure by</li> </ul>	42 CFR. Part II. The Federal rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitted by the wri	tten consent of the person to whom it pertains or otherwise permitted by 42
CFR, Part II.	
<ul> <li>In compliance with MN Statute 144,292 and WI Administrative Code HFS 117, I may supervising inspection of medical/dental records.</li> </ul>	/ be required to pay a fee for retrieval and photocopying of records and/or
<ul> <li>Your signature indicates that you have read and understand this form and authorize rel</li> </ul>	lease of your information as described above.
You have the right to a copy of this signed authorization.  Signature of Client, Parent or Local Bonroccurtetive.	Deter
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
Provider Name: ACT C	lient Medical Record Number:

HDC located at:  All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34 <sup>th</sup> Street, Suite #100, Superior, WI 54880
<ul> <li>         ≥ 810 E. 4<sup>th</sup> Street, Duluth, MN 55805     </li> </ul>	40 11th Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. 8, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) 🗵 release to 🖾 obtain i	from 🛮 verbal exchange
Agency or Individual:	
Address:	
	Email:
☐ Pick-up (Phone Number):	☐ Mail
Purpose of this disclosure:	
☐ Continuing Care/Treatment Planning ☐ Social Services Inv ☐ Other Purpose (Specify):	rolvement
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service note will	II be released.
The following information may be disclosed: (Pertinent, minimum	m necessary to accomplish the stated purpose)
	Medication Records
• • • • • • • • • • • • • • • • • • • •	Progress Notes   Treatment Plan
☐ Social Services Reports/Interventions ☐ I	Emergency Room Records   Lab Results
☐ School Reports: Grades, Behaviors, IEP ☐ I	Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
RESTRICTION: State and federal law protect the following inform	nation. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Hea	lth
• This authorization lasts for one year after the signed date <u>unless</u> you enter a diff	ferent expiration date here:
• This authorization may be canceled in writing at any time. A cancellation will no	ot change releases that have been honored before the cancellation. HDC's Notice of
Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based of	on whether or not I sign this authorization.
• A photocopy/fax of this authorization will be treated in the same way as an original state of the same way as a same way as	
HDC records may include records from other organizations that were used for make the property of the prop	ny treatment. ation who receives your records under this authorization, and that information may
not be covered by state and federal privacy protections after it is released. By sign	ning this authorization, you release HDC from any and all liability resulting from a re-
disclosure by the recipient.	
disclosure of this information unless further disclosure expressly is permitted by t	ure by 42 CFR, Part II. The Federal rules prohibit you from making any further re- the written consent of the person to whom it pertains or otherwise permitted by 42
CFR, Part II.  In compliance with MN Statute 144.292 and Wi Administrative Code HFS 117	, I may be required to pay a fee for retrieval and photocopying of records and/or
supervising inspection of medical/dental records.  • Your signature indicates that you have read and understand this form and autho	orize release of your information as described above.
You have the right to a copy of this signed authorization.  Signature of Client, Parent, or Legal Representative:	Date:
Signature of Cheff, Parent, of Legal Representative.	Date.
FOR OFFICE USE ONLY	Client Stadies   Decord Number
Provider Name: ACT	Client Medical Record Number:

HDC located at:  All HDC Locations (See Primary Agency Address below)	☐ 325 11 <sup>th</sup> Ave., Two Harbors, MN 55616
☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)	☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
810 E. 4 <sup>th</sup> Street, Duluth, MN 55805	40 11th Street, Cloquet, MN 55720
☐ 120 W. 2 <sup>nd</sup> Street, Duluth, MN 55802	☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720
Name:	Previous Name:
Last, First, MI	Birth date:
I authorize HDC to: (check all that apply) ⊠ release to ⊠ obtain from	ı ⊠ verbal exchange
Agency or Individual:	
Address:	
Method of Disclosure: ☐ Fax: ☐ Ema	ail:
☐ Pick-up (Phone Number):	☐ Mail
Purpose of this disclosure:	
☐ Continuing Care/Treatment Planning ☐ Social Services Involve	ement   Personal Records   Legal
☐ Other Purpose (Specify):	
Indicate Date(s) of Service of records to be released:	
If no specific dates are listed, only the most recent service note will be	
The following information may be disclosed: (Pertinent, minimum ne	
	lication Records ☐ Discharge Summary tress Notes ☐ Treatment Plan
-	gress Notes   Treatment Plan  In the property of the property
	nostic Assessment/Psych. Eval/Initial and/or Comp. Eval.
☐ Other (Specify Record Type(s):	
C other (openly needs a type   3).	
RESTRICTION: State and federal law protect the following information	on. ONLY indicate if you <u>DO NOT</u> authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health	
• This authorization lasts for one year after the signed date unless you enter a different	t expiration date here:
<ul> <li>This authorization may be canceled in writing at any time. A cancellation will not cha</li> </ul>	
Privacy Practice describes how to cancel (revoke) this authorization.  • HDC may not place conditions on my treatment, payment, or operations based on wh	nether or not I sign this authorization
<ul> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> </ul>	teries of hot 13gh dis socionadus.
HDC records may include records from other organizations that were used for my treatment.	
<ul> <li>HDC cannot prevent re-disclosure of your information by the person or organization not be covered by state and federal privacy protections after it is released. By signing the</li> </ul>	
disclosure by the recipient.	ms addictization, you release the nom any and an nabinty resulting from a re-
Chemical dependency/substance abuse records are protected from re-disclosure by	y 42 CFR, Part II. The Federal rules prohibit you from making any further re-
disclosure of this information unless further disclosure expressly is permitted by the w CFR, Part II.	ritten consent of the person to whom it pertains or otherwise permitted by 42
• In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I ma	ay be required to pay a fee for retrieval and photocopying of records and/or
<ul> <li>supervising inspection of medical/dental records.</li> <li>Your signature indicates that you have read and understand this form and authorize read</li> </ul>	release of your information as described above.
<ul> <li>You have the right to a copy of this signed authorization.</li> </ul>	
Signature of Client, Parent, or Legal Representative:	Date:
FOR OFFICE USE ONLY	
Provider Name: ACT	Client Medical Record Number:



#### 1401 East 1<sup>st</sup> Street, Duluth, MN 55805 AUTHORIZATION FOR COMMUNICATION VIA TEXTING

CLIENT NAME:			
Last	First	Middle	Birth date
I hereby authorize and request that the	staff of Human Development Center	(HDC) to communicate with me through	texting. I agree to the limitations as
outlined below. I understand that:			
<ul> <li>Texting should NOT be used in</li> </ul>	for crisis situations. In the event of a	crisis, I should call the crisis line at (800	) 634-8775 for MN or
(715) 395-2259 for WI or dial	911 for an emergency.		
The purpose of texting to pro	ovide an alternate means of communi	cation and will only be used when agre	ed upon between me and
HDC staff member(s) by com	pletion of this authorization.		
<ul> <li>Texting is not a confidential,</li> </ul>	secure method of communication.		
<ul> <li>If phone is lost, misplaced, or</li> </ul>	accessed by others, information cou	ld possibly be discovered by an unauth	orized individual.
Texting cannot be used by the	e provider for communicating confide	ential client/treatment information (for	example, diagnosis or
medication information)			
<ul> <li>Text communication is not al</li> </ul>	ways transmitted in a timely manner	and may not be received by staff imme	ediately when sent.
<ul> <li>I may not receive a timely res</li> </ul>	sponse to texts from my provider. Inq	uiries will be responded to during norm	nal business hours as the
provider has time.			
Texting is meant to be used w	when other methods of communication	n are not feasible.	
The Human Development Cer	nter will not condition treatment on t	he completion of this authorization.	
REVOCATION AND EXPIRATION OF CON This consent will stay in effect unless re department at the Human Development reserves the right to require an original authorization.	evoked by the client. I understand that t Center. A photocopy of this authoriza	ation may be treated in the same manne	er as the original. However, HDC
Client Signature	Signature of Pare	nt/Guardian	
Date	Relationship to C	lient	
Witness	Reason acting on	client's behalf	

THIS FORM WILL BE ACCEPTED ONLY IF ALL ITEMS HAVE BEEN COMPLETED

IF CLIENT IS UNABLE TO SIGN, THE PERSON SIGNING THE AUTHORIZATION WILL BE REQUIRED TO SHOW PROOF OF GUARDIANSHIP, OR OTHER AUTHORITY

1/2015	Client Name:
	MR #

AND RELATIONSHIP TO CLIENT ALLOWING HIM/HER TO AUTHORIZE THE RELEASE OF INFORMATION.