Northland Christian Counseling Center

2315 Library Circle; Grand Forks, ND 58201
Phone: 701-795-8550 Toll Free: 877-795-6222
Fax: 701-746-5523

AUTHORIZATION FOR RELEASE OF INFORMATION AND DISCLOSURE

Name of Client _____ Date of Birth _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

The above-named individual authorizes Northland Christian Counseling Center to exchange, release and/or receive, as described below, confidential information to/from:

Name of Person/Agency _____ Phone _____ Fax _____

Street Address _____ City _____ State _____ Zip _____

Information to be used and disclosed between entities listed (Check all that apply)

- ☐ Acknowledgement of Client's Access of Service
- ☐ Any Information Pertinent to Treatment or Plan.
- ☐ Psychological Evaluation
- ☐ Termination Summary
- ☐ Billing Information
- ☐ Intake Assessment, Recommendations and/or Diagnosis
- ☐ Progress notes (specify dates) from_____to_____
- ☐ Psychiatric Evaluation
- ☐ Alcohol and Drug Evaluation
- ☐ Other_____

I Authorize (select one)

☐ The release of all pertinent chart records selected above. ☐ The release of all pertinent chart records selected above, until ____/____/_____.

This release is valid for one year from the date signed. Note:this authorization, except for action already taken, can be revoked by client at any time.

Purpose: The purpose of this release is to facilitate the assessment, progress in treatment, treatment planning, billing, and/or discharge planning regarding the client who has accessed the above NCCC entity for evaluation/treatment services.

Other:_____

Information may be communicated or disclosed under this authorization in any form or medium, including oral, written, and/or by facsimile.

Review of Notice:

- This authorization is voluntary and remains in effect one year from the date signed unless a specific date was indicated. I understand I may revoke this consent at any time by written notice to NCCC. Any information disclosed prior to the written revocation of this authorization shall not be a breach of confidentiality.
- I understand that in the event I am authorizing the disclosure of my treatment information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law.
- NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: This information has been disclosed to you from records protected by federal confidentiality rules 42 CFR part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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.
- I understand that I am entitled to a copy of this Authorization for Release of Information and Disclosure upon request.
- I understand a photocopy of the authorization is as valid as the original.

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND THE CONDITIONS OF THIS RELEASE AND I GIVE MY AUTHORIZATION TO RELEASE INFORMATION VOLUNTARILY.

_____ _____
Client or Authorized Signature Date

_____
Print Name

_____
Relationship to Client (if client is unable to sign)