Moorhead, MN 56560 891 Belsly Blvd. Ph:. 218-287-4338 Toll Free: 866-455-6417 Fax: 218-287-5928
Waite Park, MN 56387 423 Great Oak Dr. Ph: 320-281-5305 Fax: 320-281-5306
Fergus Falls, MN 56534 1806 Fir Ave E. Ste. 200 Ph: 218-998-2992 Fax: 320-323-4357
Alexandria, MN 56308 512 30TH Ave. E. Ste. 100 Ph: 320-762-5411 Fax: 320-762-0829
Detroit Lakes, MN 56501 1104 West River Rd. Ph: 218-844-6853 Fax: 218-844-6854
Fargo, ND 58103 1126 Westrac Dr. Ph: 701-412-2973 Fax: 701-237-4407

Client Name:	**Client Date of Birth:** ____/_____/________	**Client Chart Number:**

CONTINUITY OF CARE

· **Client declined to provide PCP contact**

PLEASE SEND REQUESTED INFORMATION TO THE OFFICE CHECKED BELOW.

	Moorhead, MN	891 Belsly Blvd, 56560	Ph. 218-287-4338	Fax. 218-287-5928
	Detroit Lakes, MN	1104 West River Road, 56501	Ph. 218-844-6853	Fax. 866-226-6130
	Fergus Falls, MN	806 East Fir Ave, Ste 200, 56537	Ph. 218-998-2992	Fax. 320-323-4357
	Alexandria, MN	512 30th Ave. E., Ste 100, 56308	Ph. 320-762-5411	Fax. 320-762-0829
	Sauk Centre, MN	508 Main Street S., 56378	Ph.320-351-4871	Fax.320-351-4871
	Waite Park, MN	423 Great Oak Dr., 56387	Ph. 320-281-5305	Fax.320-281-5306
	Fargo, ND	1126 Westrac Dr., 58103	Ph.701-412-2973	Fax.701-237-4407

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby voluntarily authorize and request SOLUTIONS Behavioral Healthcare Professionals to request and disclose individually identifiable health information prepared, received and maintained by SOLUTIONS in its medical record dedicated to the Client identified above with the following entity or individual:

For releases to non-treating providers, please designate a specific individual and their contact information.

Name and Address of Provider, Entity, and/or Person: ____
____

I understand I have a right to obtain, upon request, a list of entities to whom their information has been disclosed, pursuant to the general designation as covered in 42 CFR, § 2.31.

I understand that medical record information may contain sensitive information such as that related to treatment of drug or alcohol abuse, mental health conditions, HIV/AIDS, or STD, etc. The information that I hereby authorize to be released is limited to those items indicated below:

I authorize release of all alcohol and/or drug treatment records that are part of the records I specified above unless indicated otherwise below:

Do not release alcohol and/or drug treatment records protected under 42 CFR Part 2.

_x_Entire Medical Record
___Recommendations
___Risk Management Assessment
___Psychiatric Evaluation
___Testing Results
___Medication
___Lab Reports/Results
___IEP/School Testing/Reports
___Progress/Case Notes
___Treatment/Program Plan
___Admission/Discharge Reports
___Psychological Evaluation
_x_Verbal & Written Exchange
___Behavior Plan
___Diagnostic Assessment

___Third Party Information (provided to Solutions by other providers, specify):______________

___Other (specify)______________

The information may be used and disclosed for the purposes indicated below:
___Diagnostic Evaluation _x_ Coordination & Follow-Up
___Treatment Planning ___Disability Determination
___Claim Payment ___Legal Action/Review
___Other Purpose (specify):______________

This authorization expires one year from the date of signature on this form unless a specific date, event, or condition is described here:__________________________

I understand that I may revoke this authorization through a written request that is signed, dated, and effectively presented to SOLUTIONS. I understand that exceptions to my right to revoke this authorization are described in the Notice of Privacy Practices that I received upon admission to SOLUTIONS. I also understand that such a revocation cannot apply to information already released by the clinic.

I also understand that if the entity or person that I authorize to receive medical record information is not a provider, health plan, or covered entity, the released information could be re-disclosed and such disclosure may not be protected by federal privacy regulations. I understand that SOLUTIONS will not condition its treatment of the client identified above on whether or not this form is signed unless otherwise required or permitted by law or as described in the Notices of Privacy Practices. I understand that the information may be transmitted on paper or electronically, and that SOLUTIONS complies with State and Federal laws regarding the transmission of PHI. See Minnesota Statutes Chapter 325L, Uniform Electronic Transactions Act and North Dakota Century Code Chapter 9-16, Electronic Transactions.

a.) A record or signature may not be denied legal effect or enforceability solely because it is in electronic form.

b.) A contract may not be denied legal effect or enforceability solely because an electronic record was used for its formation.

c.) If a law requires a record to be in writing, an electronic record satisfies the law.

d.) If a law requires a signature, an electronic signature satisfied the law.

(This Authorization for Use and Disclosure of Protected Health Information form will be kept in the medical record)

THIS AUTHORIZATION MUST BE EFFECTIVELY SIGNED BEFORE RECORDS WILL BE RELEASED. RELEASE OF RECORDS MAY BE SUBJECT TO A CHARGE PURSUANT TO MINNESOTA AND/OR NORTH DAKOTA LAW.

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. § 2.32). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

The violation of the federal law and regulations under 42 CFR Part 2 is a crime. In compliance with 42 CFR Part 2, § 2.22(b)(2), you have the right to report a suspected violation to the District's US Attorney's office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the HIPAA Privacy & Security policies and procedures of our office. We will not retaliate against you for filing a complaint. The contact information is located on the Notice of Privacy Practices. You may request a copy of this at any time.

Signature of Client or Parent/Guardian:	**Printed Name of Signer:**	**Date of Signature:** ____/_____/________

Signature of Client or Parent/Guardian:	**Printed Name of Signer:**	Date of Signature: ____/_____/________

Dear (Provider) ____, the above identified client has identified you as either a Primary Care Provider or another professional providing treatment.

Solutions Behavioral Healthcare Professionals makes every effort to establish and maintain a working relationship with each client's Primary Care Provider as well as other professional providers, to ensure quality and continuity of care for the client. This client has started services through our agency and may be provided one or more of the following services:

- Outpatient Psychotherapy
- DBT Programming
- Case Management
- Adult Rehabilitative Mental Health Services or Child Therapeutic Support Services
- Psychiatric Evaluation/Medication Management
- Psychological Evaluation

*We ask that you please complete the PROVIDER portion at the bottom of this page and return to our office within one week if at all possible.

WE ARE NOT REQUESTING ANY FURTHER RECORDS AT THIS TIME.

Thank you

PROVIDER Name: (if different than above information) ____

___ Primary Care Provider ____ Other Professional Service Provider

Provider's treating diagnosis: ______________
Any specific recommendations or information that would be beneficial to Solutions in treating this client?

Provider Signature: _______________________________ Date: ____________________