FAMILY VOICES OF NORTH DAKOTA®
Navigating Crossroads to Hope

Information to be used or disclosed in connection with Pediatric Mental Health Care Access Program

Authorization for Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	
Phone Number:	Email:

Instructions: Fill out each section of this form completely.

Authorizes Family Voices of ND to Release Information between the following agencies:

Name/Facility:	Consultant:
Address: (City/State/Zip Code)	Fax #:
Phone Number:	Email:

To Release Information To and From:

Name/Facility:	Phone Number:
Address: (City/State/Zip Code)	Fax #:

Purpose of Release:

☐ Coordination of Care Planning	☐ Application for Insurance
☐ Acknowledgement of Services	☐ Other:_____

Information to be Released:

☐ Assessment	☐ Diagnosis
☐ Treatment Progress	☐ **Demographic Information**
☐ Educational Information	☐ Other:_____

Information may be Released by:

☐ Mail	☐ Pick-up	☐ Phone	☐ Fax	☐ Electronic/Video

Authorization for this information remains in effect for 1 year from the date signed unless another expiration date is provided. I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation in not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To and From" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal will not affect my ability to obtain treatment, receive treatment, or my eligibility for benefits. **SUBSTANCE USE DISORDER INFORMATION** is protected under federal regulations governing Confidentiality of Substance Use Disorder Patient Records; 42 C.F.R. Part 2 and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years and older is required to disclose substance use disorder information. Both the signature of the minor 13 years and younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

Signature of client:	Date:
Signature of Parent (Guardian)(required)	Date:

Family Voices Fax# 701-493-2635 or *secure* email to feist@drtel.net