



RELEASE OF INFORMATION AUTHORIZATION FORM LEGAL PROCEEDINGS

Patient Information	Client Full Name	Client ID	Date of Birth												
Purpose of Release:	<input type="checkbox"/> Consent to disclose records for civil, criminal, administrative, or legislative proceeding. (42 CFR 2.31d)														
Release Information FROM:	<input type="checkbox"/> Spero Substance Use and Recovery Program <input type="checkbox"/> Spero Medical Records <input type="checkbox"/> Name of specific person(s):														
Release/Send Information TO:	<input type="checkbox"/> A Specific Individual/Organization:														
	Street Address		Phone Number												
	City	State	Zip Code Fax Number												
Information to be Released:	<p>*Substance Use Disorder Records are the records that identify an individual as currently or previously having a substance or alcohol use disorder and contain information on the diagnosis, treatment, progress, or referral for treatment (42 CFR 2.12). This includes information on recovery and maintenance of sobriety from substance or alcohol use.</p> <p><input type="checkbox"/> General -and/or- <input type="checkbox"/> Substance Use Disorder (SUD) Treatment Records:</p> <p>1. <input type="checkbox"/> Health records for specific dates of service: _____</p> <p>2. The following records:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Assessments/Evaluations</td> <td><input type="checkbox"/> Admission/Discharge Summary</td> <td><input type="checkbox"/> Itemized Billing Statements</td> </tr> <tr> <td><input type="checkbox"/> Letters</td> <td><input type="checkbox"/> Medications/Lab Reports</td> <td><input type="checkbox"/> Progress Notes</td> </tr> <tr> <td><input type="checkbox"/> Psychiatric Reports</td> <td><input type="checkbox"/> Summary of Care</td> <td><input type="checkbox"/> Testing Results</td> </tr> <tr> <td><input type="checkbox"/> Treatment Plans</td> <td><input type="checkbox"/> Verbal Communication</td> <td><input type="checkbox"/> Other:</td> </tr> </table> <p>-or-</p> <p>3. <input type="checkbox"/> Verbal Testimony</p>			<input type="checkbox"/> Assessments/Evaluations	<input type="checkbox"/> Admission/Discharge Summary	<input type="checkbox"/> Itemized Billing Statements	<input type="checkbox"/> Letters	<input type="checkbox"/> Medications/Lab Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Psychiatric Reports	<input type="checkbox"/> Summary of Care	<input type="checkbox"/> Testing Results	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Verbal Communication	<input type="checkbox"/> Other:
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Release Method:	<input type="checkbox"/> Pick-up at the Owatonna Spero location (Photo ID required) <input type="checkbox"/> Fax (list above) <input type="checkbox"/> Secure -or- <input type="checkbox"/> Unsecure Email: _____ <input type="checkbox"/> Mail (list above) <input type="checkbox"/> Verbal <input type="checkbox"/> Court Appearance														
Authorization and Signature:	This authorization will expire in one (1) year from the date of signature unless otherwise specified: Date: _____ or specific event: _____.														
	<input type="checkbox"/> By checking this box I allow ongoing exchange of information between the above parties for the length of this authorization. <input type="checkbox"/> By checking this box I allow for future records of services received to be included within this authorization.														
	<ul style="list-style-type: none"> I understand that my health information is protected by federal and state privacy laws and records can only be released with a signed authorization. I understand that Spero will not condition treatment, payment, or eligibility on whether I sign this authorization. I, or others, may be charged for copies in accordance with state law. This authorization may be revoked at any time by completing the revoke section on the bottom of page 2 and submitting it to Spero Medical Records for processing. Information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. 														
	<p>Note: Adult and Minor clients must authorize the release of their own information unless the client is incapacitated or deceased.</p>														
	Signature	Date (mm/dd/yyyy)													
	Printed Name of Person Signing (if not the Client)	Relationship to Client													

Instructions for completing the Release of Information Authorization Form

To protect our client's confidential medical and personal information, we must have a valid, complete, and legible authorization to release their health information.

1. **Patient Information:** Clearly print all requested client demographics.
2. **Purpose of Release:** Indicate reason for releasing health information.
3. **Release Information FROM:** Check the appropriate box(es) for who is authorized to release your records.
4. **Release/Send Information TO:** Select the appropriate option. If you want your health information sent to a specific individual/organization be sure to include complete and accurate demographic information to ensure records are sent to the correct location.
5. **Information to be Released:** In this section you will tell us what information or records you need. Select the type(s) of information to be released.
6. **Release Method:** Tell us how you would like your records delivered to the party identified in #4. Be sure to verify all required fields are complete and accurate. If you select "unsecure" email, you understand and accept the risks of this option.
7. **Authorization and Signatures:** The client must sign and date the authorization in order for it to be valid.
8. **Revocation:** Complete this section to revoke or end your authorization to release information to the party identified #4. Ensure this is provided to Medical Records for processing. If for court ordered services, this authorization will be revoked no later than final disposition of conditional release or other action in connection with this consent (42 CFR 2.35).

If you need help completing this for, you can contact Spero's Medical Records staff at:

- Phone: 507-413-6081
- Email: MedicalRecords@speromn.org
- Fax: 507-455-8133, Attn: Medical Records

Staff are available to answer calls and emails during the times listed below:

Monday thru Friday, 8:00am – 4:30pm. We are closed Saturdays, Sundays and major Holidays.

Complete the below section to Revoke your authorization to release information to the party identified on page 1.

Revocation:	Signature	Date (mm/dd/yyyy)
	Printed Name of Person Signing (if not the Client)	Relationship to Client