



RELEASE OF INFORMATION AUTHORIZATION FORM SPECIAL CONSENT

Patient Information	Client Full Name	Client ID	Date of Birth
Purpose of Release:	<input type="checkbox"/> Coordination of Care <input type="checkbox"/> Personal/My Request <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Other:		
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"/> My treating providers, health plans, third-party payers, and their business associates for all future uses and disclosures for treatment, payment, and health care operations. (42 CFR 2.31a) <input type="checkbox"/> To the person(s) or group(s) within the Criminal Justice System who monitor my progress. (42 CFR 2.35) <input type="checkbox"/> A Specific Healthcare Provider/Organization or Criminal Justice System -Specify selection below-		
	Street Address		Phone Number
	City	State	Zip Code Fax Number
Information to be Released:	1. <input type="checkbox"/> Psychotherapy Notes – HIPAA Protected (45 CFR 164.508) -or- 2. <input type="checkbox"/> SUD Counseling Notes – HIPAA Part 2 Protected (42 CFR 2.31b)		
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		
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, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Federal law prohibits the recipient of SUD records from making any further disclosure of this information without the specific written consent of the person whom it pertains, or as otherwise permitted. (42 CFR 2.32) 		
	Note: An adult client (18 years or older) must authorize the release of their own information unless client is incapacitated or deceased. <i>Specific situation(s) may only require the minor's authorization.</i> If signing for a minor client, I hereby state that my parental rights have not been revoked by a court of law. Legal documentation of the right of access by the signing individual may be required.		
	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.

- Patient Information:** Clearly print all requested client demographics.
- Purpose of Release:** Checking this box will assist us in tracking, assigning priority and who may be responsible for the cost of records, if appropriate.
- Release Information FROM:** Check the appropriate box(es) for who is authorized to release your records.
- Release/Send Information TO:** Select the appropriate option and specify a specific individual/organization/other healthcare provider. Include complete and accurate demographic information to ensure records are sent to the correct location.
- Information to be Released:** In this section you will tell us what information or records you specifically need. Each option listed has extra regulatory protection and needs your special consent. In compliance with federal law, special consent is required to release the following records and cannot be combined with any other consent
- 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.
- Authorization and Signatures:** The client or their legal representative must sign and date the authorization in order for it to be valid. If you are a legal representative, indicate your relationship to the client in the space provided. You may be asked to provide documents showing that you are the client's legal representative.
- 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 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