RELEASE OF INFORMATION AUTHORIZATION FORM
GENERAL

Patient Information	Client Full Name	Client ID	Date of Birth
Purpose of Release:	☐ Coordination of Care ☐ Personal/My Request ☐ Legal ☐ Disability ☐ Transfer of Care ☐ Insurance ☐ Other:		
Parties:	**Spero** 610 Florence Ave, Owatonna, MN 55060 P: 507-451-2630 F: 507-455-8133 To do the Following: ☐ Release Information To ☐ Receive Information From ☐ Both, Release & Receive	With Organization / Contact Person: _____ _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____ Fax Number: _____ Email Address: _____	
Information to be Released:	*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. *-Specify selection below-* ☐ General -and/or- ☐ Substance Use Disorder (SUD) Treatment Records: 1. ☐ Health records for specific dates of service: _____ 2. The following records: ☐ Assessments/Evaluations ☐ Admission/Discharge Summary ☐ Healthcare Portal ☐ Itemized Billing Statements ☐ Letters ☐ Medications/Lab Reports ☐ Progress Notes ☐ Psychiatric Reports ☐ Summary of Care ☐ Testing Results ☐ Treatment Plans ☐ Verbal Communication ☐ Other:		
Release Method:	☐ Pick-up at the Owatonna Spero location (Photo ID required) ☐ Fax (list above) ☐ Secure -or- ☐ Unsecure Email (list above) ☐ Mail (list above) ☐ Verbal ☐ Healthcare Portal		
Authorization:	This authorization will expire in **one (1) year** from the date of signature unless otherwise specified: Date: _____ or specific event: _____. ☐ By checking this box I allow for future records of services received to be included within this authorization. • I understand that my health information is protected by federal and state privacy laws and records can only be released with a signed authorization. • 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. Except for any court ordered services. • 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)		
Signature:	**Note:** An adult client (18 years or older) must authorize the release of their own information unless client is incapacitated or deceased. *Specific situation(s) may only require the minor's authorization*. 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.

1. **Patient Information:** Clearly print all requested client demographics.
2. **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.
3. **Release Information FROM:** Check only one of the boxes. If for SUD records, please specify: Substance Use & Recovery Program, Medical Records, or specific person(s).
4. **Release/Send Information TO:** Print where you want your health information sent (e.g. individual, organization, other healthcare provider). 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 including whether you wish to include any SUD records.
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 or their legal representative must sign and date the authorization 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.
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 or have questions completing this form, 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