NORTH DAKOTA AUTHORIZATION TO DISCLOSE INFORMATION

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The person or organization will not condition treatment on your agreement to authorize disclosure of your health information. The person or organization may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a health plan.

Name of Client (Last, First, Middle Initial)	Social Security Number		Date of Birth
Previous Names Used			
Street Address	City	State	ZIP Code

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Street Address	City	State	ZIP Code

2. Permission To: ☐ Disclose To ☐ Obtain From ☐ Mutually Exchange With

Name of Person/Agency	Email Address (complete ONLY if email delivery is requested)		
Street Address	City	State	ZIP Code

3. Provide a detailed description of the information to be disclosed, including how much and what kind of information. (See instructions)

4. The information identified above will be used for: (Select all that apply)

☐ Coordination of Care/Treatment/Discharge Planning ☐ Legal ☐ At the Request of the Individual
☐ Billing/Payment ☐ Eligibility Determination ☐ Collateral
☐ Other (must specify to be valid): _____

5. Authorization remains in effect for one year from date signed unless a different expiration date is entered here (MM/DD/YYYY):

CLIENT CONSENT

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the person or organization's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the 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 of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or 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 or Custodian (if needed)	Relationship	Date
Signature of Witness (if needed)		Date

☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING SUBSTANCE USE DISORDER PATIENT RECORDS:** 42 CFR Part 2 prohibits unauthorized disclosure of these records.

DISTRIBUTION: ☐ To agency/person from whom information is sought ☐ Client ☐ Other
☐ Requesting Agency ☐ Client refused copy