# HUMAN DEVELOPMENT CENTER
# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The Human Development Center located at: (***please check correct address***):

- ☐ 1401 East First Street Duluth, MN 55805
- ☐ 325 11th Ave Two Harbors, MN 55616
- ☐ ACT, 1402 East 2nd Street Duluth, MN 55805
- ☐ 40 11th Street Cloquet, MN 55720
- ☐ 810 E. 4th Street, Duluth, MN 55805
- ☐ P.O. Box 847, 1807 West Hwy 61 Grand Marais, MN 55604
- ☐ T-ACT, 31 W. First Street Duluth, MN 55802
- ☐ 1500 North 34th Street Suite #100 Superior, WI 54880
- ☐ Carlton County ACT, 1103 Ave B Suite 200 Cloquet, MN 55720

Name: _____ Previous Name: _____
Last, First MI Birth date: _____

**I authorize the Human Development Center to**: *(check all that apply)* ☐ **release to** ☐ **obtain from** ☐ **verbal exchange**
Agency or Individual: _____

Address: _____

**Method of Disclosure:** ☐ Fax: _____
☐ Pick-up (Phone Number): _____ ☐ Mail

**State and federal law protect the following information. Please indicate if you would NOT like this information released:**
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

**Purpose of this disclosure:**
☐ Continuing Care/Treatment Planning ☐ Social Services Involvement ☐ Personal Records ☐ Legal
☐ Other Purpose *(Specify)*: _____

**Indicate Dates of Service(s) of records to be released:** _____
*If no specific dates are listed, only the most recent service note will be released.*

**The following information may be disclosed:** *(Pertinent, minimum necessary to accomplish the stated purpose)*

| | | |
|---|---|---|
| ☐ Medical History/History and Physical Exam | ☐ Medication Records | ☐ Discharge Summary |
| ☐ Diagnostic Assessment/Psych. Evaluation | ☐ Progress Notes | ☐ Treatment Plan |
| ☐ Social Services Reports/Interventions | ☐ Emergency Room Records | ☐ Lab Results |
| ☐ School Reports: Grades, Behaviors, IEP | ☐ Other *(Specify Record Type(s)*: _____ | |

This authorization lasts for one year after the signed date unless you enter a different expiration date here: _____

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happened before the cancellation. The Human Development Center's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- The Human Development Center will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Human Development Center records may include records from other organizations that were used for my treatment.
- The Human Development Center cannot prevent re-disclosure of your information by the person or organization who received your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the Human Development Center from any and all liability resulting from a re-disclosure by the recipient.
- Chemical dependency/substance abuse records are protected from re-disclosure by 42 CFR, Part II. The Federal rules prohibit you from making any further re-disclosure of this information unless further disclosure expressly is permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR, Part II.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have a right to a photocopy of this signed authorization

**Signature of Client, *Parent or Legal Representative:** _____ **Date:** _____
***Wisconsin only- By signing above, I hereby declare I have not been denied physical placement of this child.**

**FOR OFFICE USE ONLY**
Provider Name: _____ Client Medical Record Number: _____