



RELEASE OF INFORMATION

Info@libinprograms.org 320-828-2108 320-238-7682

Client Information

Client Name _____ Date of Birth _____

Previous Names (if any) _____

Address _____ Phone _____

I Authorize

Libin Health LLC To:

Release To Receive From Both Release & Receive

With

Agency/Provider/Person Name _____

Contact/Department (if known) _____

Address _____

Phone _____ Fax _____

What do you want released?

Please check all that apply:

<input type="checkbox"/> Diagnostic Assessment (DA)	<input type="checkbox"/> Functional Assessment / FA /	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Individual Treatment Plan	<input type="checkbox"/> Nursing Notes	<input type="checkbox"/> MAR
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Case Management
<input type="checkbox"/> Collateral Information	<input type="checkbox"/> Legal / Court Documents	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Continuity & Coordination of Care	<input type="checkbox"/> Legal / Court	<input type="checkbox"/> Case Management
<input type="checkbox"/> Housing	<input type="checkbox"/> Insurance	<input type="checkbox"/> Client Request/Personal
<input type="checkbox"/> Other (specify): _____		

Purpose of Release

Substance Use Disorder (SUD) Information

I authorize the release of Substance Use Disorder (SUD) treatment information protected under 42 CFR Part 2:

Dates of SUD Records: From _____ Dates of SUD Records: To _____

SUD Assessment SUD Progress Notes SUD Discharge Summary

SUD Weekly Notes Other (specify): _____

Method of Release

Mail Fax Email Verbal Pick-Up

Authorization

*This authorization expires **one** year from the date signed unless a different date/event is written here:*

Client Signature _____ **Date** _____

If signed by an authorized representative:

Parent of Minor Legal Guardian Health Care Agent / POA

Name _____ **Relationship** _____

Signature _____ **Date** _____

Disclaimer: Libin Health LLC will not condition treatment, admission, payment, enrollment, or eligibility for benefits on whether you sign this authorization. Once information is released according to this authorization, Libin Health LLC cannot guarantee that the recipient will not redisclose the information. This authorization may include mental health, developmental disability, HIV/AIDS, and other sensitive health information as permitted by law. If Substance Use Disorder (SUD) information is included, it is protected under 42 CFR Part 2, and federal law prohibits the recipient from redisclosing SUD information without your written permission unless allowed by law; a general authorization is not sufficient for the release or redisclosure of SUD information. You may revoke this authorization at any time by submitting a written request to Libin Health LLC, but the revocation does not apply to information already released. Unless a different expiration date or event is stated, this authorization expires one year from the date signed and may not exceed five years, in accordance with Minnesota Statute 144.293.