HDC

Human Development Center

Comprehensive Behavioral Healthcare

Professional. Compassionate. Dedicated.

INFORMED CONSENT AND AUTHORIZATION

Consent for Treatment I give my consent to the Human Development Center (HDC) providers and support staff to provide, coordinate, and/or manage behavioral health services for me.

Authorization for Disclosure of Protected Health Information (PHI) As explained in the Notice of Privacy Practices, I authorize disclosure of my protected health information for the purpose of HDC's Treatment, Payment, and Healthcare Operations. HDC may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange for treatment unless I object by checking here: ☐

Examples: HDC providers from whom I accept services or treatment may share my information with other HDC providers involved in my care. I understand that for various services HDC providers are required to or designed to function as a team and will share my information within that team in a confidential manner. I understand the Consultation process between members of an HDC multidisciplinary team may include confidential discussion about a client. This case Consultation is good practice and helps to ensure high quality care for me.

Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits, or benefit payments from other sources for claims for my care originating from HDC to be paid directly to HDC. I agree to pay the balance due for any services received that are not covered by insurance or grant funding.

Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I understand the laws, rules, and regulations of these programs shall apply. I may contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118 if I have questions.

Client Information I have received the Client Information booklet informing me of HDC policies and my rights as a client.

HDC Financial policies exist that: A client is required to pay the applicable co-pay amount due at the time of each visit.

I acknowledge I have received the HDC **NOTICE OF PRIVACY PRACTICES** that explains how my health information will be handled in various situations. I understand that I can request a copy of the Notice of Privacy Practices from HDC. I understand an electronic copy of the HDC NOTICE OF PRIVACY PRACTICES can be found at https://www.humandevelopmentcenter.org/.

I have been given the opportunity to discuss my concerns and questions about the privacy of my health information, or I may contact the HDC Privacy Officer at 1401 East First St., Duluth, MN 55805 or toll-free 888-412-9764.

This authorization is valid for one year from the date of signature. I may revoke this consent and authorization at any future time upon written notice to HDC.

Signature _____ **Date** _____

Printed Name _____

If I am signing as an authorized representative of the client, I am: (Circle one)

*Parent of a minor *Court Appointed guardian/conservator *Power of Attorney for Healthcare

**Must provide documentation of guardianship, conservatorship, power of attorney for healthcare*

Staff must document any refusal to sign

Client Name_____

Client # _____

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **St. Louis County PHHS**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☐ Other *(Specify Record Type(s)*: _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

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- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Center of Alcohol & Drug Treatment (CADT)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

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☒ Medical History/History and Physical Exam	☒ Medication Records	☒ Discharge Summary
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☐ Other *(Specify Record Type(s)*: _____

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Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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Provider Name: ACT Client Medical Record Number: _____

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Genoa Pharmacy**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

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- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Social Security Administration (SSA)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

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☐ Other *(Specify Record Type(s))*: _____

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Last, First, MI Birth date: _____

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Essentia Health**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

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Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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Provider Name: ACT Client Medical Record Number: _____

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **St. Luke's Hospital/Clinics**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

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Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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Provider Name: ACT Client Medical Record Number: _____

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Duluth Family Medicine Clinic (DFMC)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

Purpose of this disclosure:
☒ Continuing Care/Treatment Planning ☐ Social Services Involvement ☐ Personal Records ☐ Legal
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Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

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Name: _____ Previous Name: _____
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I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Thrive Behavior Network (Birch Tree Center)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

Purpose of this disclosure:
☒ Continuing Care/Treatment Planning ☐ Social Services Involvement ☐ Personal Records ☐ Legal
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☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

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- This authorization may be canceled in writing at any time. A cancellation will not change releases that have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Prairie St. John's (ND)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☐ Other *(Specify Record Type(s))*: _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Representative payee:**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☒ Other *(Specify Record Type(s))*: **Payee services/needs**

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Housing & Redevelopment Authority (HRA)**

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☒ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☒ Other *(Specify Record Type(s))*: **Housing**

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Landlord:** _____

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☒ Other *(Specify Record Type(s))*: **Housing** _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
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- ☐ 120 W. 2nd Street, Duluth, MN 55802
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- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Employment:** _____

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☒ Chemical Dependency/Substance Use Notes	☒ Progress Notes	☒ Treatment Plan
☒ Social Services Reports/Interventions	☒ Emergency Room Records	☒ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☒ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☒ Other *(Specify Record Type(s)*: **Employment services/needs**

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
- ☒ 810 E. 4th Street, Duluth, MN 55805
- ☐ 120 W. 2nd Street, Duluth, MN 55802
- ☐ 325 11th Ave., Two Harbors, MN 55616
- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: **Family/Friend:** _____

Address: _____

Method of Disclosure: ☒ Fax: _____ ☒ Email: _____
☒ Pick-up (Phone Number): _____ ☒ Mail

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

Indicate Date(s) of Service 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
☐ Chemical Dependency/Substance Use Notes	☐ Progress Notes	☐ Treatment Plan
☐ Social Services Reports/Interventions	☐ Emergency Room Records	☐ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☐ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☒ Other *(Specify Record Type(s)*: **In case of Emergency (ICE)**

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
- ☐ 1401 E. 1st Street, Duluth, MN 55805 (Primary Agency Address)
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- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: _____

Address: _____

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

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

Indicate Date(s) of Service 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
☐ Chemical Dependency/Substance Use Notes	☐ Progress Notes	☐ Treatment Plan
☐ Social Services Reports/Interventions	☐ Emergency Room Records	☐ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☐ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☐ Other *(Specify Record Type(s)*: _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
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- 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HDC located at:

- ☒ **All HDC Locations** (See Primary Agency Address below)
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- ☐ 1500 N. 34th Street, Suite #100, Superior, WI 54880
- ☐ 40 11th Street, Cloquet, MN 55720
- ☐ Carlton County ACT, 1103 Ave. B, Suite 200, Cloquet, MN 55720

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

I authorize HDC to: *(check all that apply)* ☒ **release to** ☒ **obtain from** ☒ **verbal exchange**

Agency or Individual: _____

Address: _____

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

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

Indicate Date(s) of Service of records to be released: _____
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The following information may be disclosed: *(Pertinent, minimum necessary to accomplish the stated purpose)*

☐ Medical History/History and Physical Exam	☐ Medication Records	☐ Discharge Summary
☐ Chemical Dependency/Substance Use Notes	☐ Progress Notes	☐ Treatment Plan
☐ Social Services Reports/Interventions	☐ Emergency Room Records	☐ Lab Results
☐ School Reports: Grades, Behaviors, IEP	☐ Diagnostic Assessment/Psych. Eval/Initial and/or Comp. Eval.	

☐ Other *(Specify Record Type(s))*: _____

RESTRICTION: State and federal law protect the following information. ONLY indicate if you DO NOT authorize for its release.
☐ Substance Abuse ☐ HIV Test Results ☐ Mental Health

- 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 have been honored before the cancellation. HDC's Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- HDC may not place conditions on my treatment, payment, or operations based on whether or not I sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- HDC records may include records from other organizations that were used for my treatment.
- HDC cannot prevent re-disclosure of your information by the person or organization who receives 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 HDC 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.
- In compliance with MN Statute 144.292 and WI Administrative Code HFS 117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical/dental records.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.
- You have the right to a copy of this signed authorization.

Signature of Client, Parent, or Legal Representative: _____ **Date:** _____

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

HDC
Human Development Center
Comprehensive Behavioral Healthcare
Professional. Compassionate, Dedicated.

1401 East 1st Street, Duluth, MN 55805
AUTHORIZATION FOR COMMUNICATION VIA TEXTING

CLIENT NAME:

_____

Last First Middle Birth date

I hereby authorize and request that the staff of Human Development Center (HDC) to communicate with me through texting. I agree to the limitations as outlined below. I understand that:

- **Texting should NOT be used for crisis situations. In the event of a crisis, I should call the crisis line at (800) 634-8775 for MN or (715) 395-2259 for WI or dial 911 for an emergency.**
- **The purpose of texting to provide an alternate means of communication and will only be used when agreed upon between me and HDC staff member(s) by completion of this authorization.**
- **Texting is not a confidential, secure method of communication.**
- **If phone is lost, misplaced, or accessed by others, information could possibly be discovered by an unauthorized individual.**
- **Texting cannot be used by the provider for communicating confidential client/treatment information (for example, diagnosis or medication information)**
- **Text communication is not always transmitted in a timely manner and may not be received by staff immediately when sent.**
- **I may not receive a timely response to texts from my provider. Inquiries will be responded to during normal business hours as the provider has time.**
- **Texting is meant to be used when other methods of communication are not feasible.**
- **The Human Development Center will not condition treatment on the completion of this authorization.**

REVOCATION AND EXPIRATION OF CONSENT:
This consent will stay in effect unless revoked by the client. I understand that I may revoke this consent to at any time by written notice to the HIS department at the Human Development Center. A photocopy of this authorization may be treated in the same manner as the original. However, HDC reserves the right to require an original consent. I understand that the Human Development Center will not condition treatment on the completion of this authorization.

_____ _____
Client Signature **Signature of Parent/Guardian**

_____ _____
Date **Relationship to Client**

_____ _____
Witness **Reason acting on client's behalf**

IF CLIENT IS UNABLE TO SIGN, THE PERSON SIGNING THE AUTHORIZATION WILL BE REQUIRED TO SHOW PROOF OF GUARDIANSHIP, OR OTHER AUTHORITY AND RELATIONSHIP TO CLIENT ALLOWING HIM/HER TO AUTHORIZE THE RELEASE OF INFORMATION.

THIS FORM WILL BE ACCEPTED ONLY IF ALL ITEMS HAVE BEEN COMPLETED

Client Name:_____

MR #_____

Community Intervention Group

AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Please Ensure All Fields On This Form Are Filled In

1. **DO NOT** sign this form as a required condition of rehabilitation.
2. Ensure that the release of information is in your best interest.

FIRST NAME **MI** **LAST NAME** **DOB**

I HEREBY AUTHORIZE THE VERBAL EXCHANGE OF PERSONAL INFORMATION TO THE FOLLOWING ENTITIES BEING PART OF THE **COMMUNITY INTERVENTION GROUP** (*See list of Agencies on second page*.)

PLEASE CHECK ALL THAT APPLY:

____ Scheduling/Appointment information
____ Medical information, including my symptoms, diagnosis, medications, and treatment plan
____ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan
____ Alcohol and/or Drug Abuse information, including my symptoms, diagnosis, medications, and treatment plan
____ Lab/test results
____ HIV related information (AIDS related testing)
____ Billing and payment information
____ Other (describe): _____

PURPOSE OF DISCLOURE

___ Continuing Care and Treatment ___ Collateral Contact ___ Other (describe) _____

- *I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.*
- *I understand that I have the right to revoke my permission at any time*
- *I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.*
- *I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.*
- *I understand that no organization may condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.*
- *I understand I will receive a copy of this form after I have signed it.*
- *I understand a photocopy or fax of this form is the same as the original.*

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

*****I AM REVOKING THIS AUTHORIZATION AT THIS TIME*****

Client Signature: _____ Date: _____ Time: _____

Community Intervention Group Members

Agency Addresses and Phone Numbers:

Accend Services: 101 W. Second Street, Duluth, MN 55802: (218) 724-3122

American Indian Community Housing (AICHO): 202 W. Second Street, Duluth, MN 55802: (218) 722-7225

Arrowhead Regional Corrections: 100 N 5th Ave W. Duluth, MN 55802: (218) 726-2633

Center City Housing Corporation: 105 ½ W. 1st Street, Duluth, MN: 55802: (218) 722-7161

Center for Alcohol and Drug Treatment (CADT): 1402 E. Superior Street, Duluth, MN 55805: (218) 723-8444

Churches United in Ministry (CHUM): 102 W. Second Street, Duluth, MN 55802: (218) 720-6521

The Damiano Center: 206 W. 4th Street, Duluth, MN 55806: (218) 722-8708

Duluth City Attorney's Office: 411 W. First Street, Duluth, MN 55802: (218) 730-5490

Duluth Family Medicine Clinic (DFMC): 330 N. 8th Ave. East, Duluth, MN 55805: (218) 723-1112

Duluth Fire Department's Division of Life Safety: 615 W. First Street, Duluth, MN 55802: (218) 730-4380

Duluth Police Department: 2030 N. Arlington Avenue, Duluth, MN 55811: (218) 730-5400

Essentia Health: 400 E. Third Street, Duluth, MN 55805: (218) 786-8364

Fond Du Lac Human Services: 927 Trettel Lane, Cloquet, MN 55720: (218) 879-1227

Housing & Redevelopment Authority (HRA): 222 E. Second Street, Duluth, MN 55805: (218) 529-6300

Human Development Center (HDC): 810 E. 4th Street, Duluth, MN 55806: (218) 728-4491

Lake Superior Community Health Center: 4325 Grand Avenue, Duluth, MN 55807: (218) 722-1497

Life House Duluth: 102 W. First Street, Duluth, MN 55802: (218) 722-7431

Minnesota Assistance Council for Veterans (MACV): 5209 Ramsey St, Duluth Mn 55807: (218)722-8763

Sixth Judicial District Court: 100 North 5th Avenue West, Duluth, MN 55802: (218) 726-2460

St. Louis County Attorney: 100 N 5th Ave W #101, Duluth, MN 55802: (218) 726-2000

St. Louis County Jail: 4334 Haines Rd, Duluth, MN 55811: (218) 726-2345

St. Louis County Public Defender's Office: 306 W Superior St # 1400, Duluth, MN 55802: (218) 733-1027

St. Louis County Public Health and Human Services: 320 W 2nd St, Duluth, MN 55802: 218-726-2222

St. Luke's Health Care System: 915 E 1st St. Duluth, MN 55805: (218) 249-5555

Thrive Behavioral Network (Birchtree Center/CRT): 4720 Burning Tree Rd, Duluth, MN 55811: (218) 623-1800

Nathan Kesti staff: Block by Block: 207 W Superior St, Suite 206 Duluth, MN 55802: (218) 340-8274

Katie Hagglund: Union Gospel Mission: 219 E First St, Duluth MN 55802: (218) 722-1196