SHS AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPECIAL HEALTH SERVICES UNIT
SFN 716 (8-2023)

Clear Fields

INSTRUCTIONS: Please Complete All Sections. Please Print.

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

CLIENT AUTHORIZATION AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Organization **Special Health Services Unit**			
Street Address **600 East Boulevard Avenue, Dept. 301**	City **Bismarck**	State **ND**	ZIP Code **58505-0200**

2. **To Disclose Information To and Exchange Information With People or Organizations Identified Below:**

Medical Services, Department of Health and Human Services (e.g., Medicaid, Healthy Steps/CHIP, etc.)			
Street Address **600 East Boulevard Avenue, Dept. 325**	City **Bismarck**	State **ND**	ZIP Code **58505-0250**
Primary Care Physician/Medical Home			
Street Address	City	State	ZIP Code
Medical Specialist/Clinic Team			
Street Address	City	State	ZIP Code
Other Medical Specialist/Facility			
Street Address	City	State	ZIP Code
Insurance Company			
Street Address	City	State	ZIP Code
Pharmacy			
Street Address	City	State	ZIP Code
County Social Service Board			
Street Address	City	State	ZIP Code
Dentist			
Street Address	City	State	ZIP Code
Orthodontist			
Street Address	City	State	ZIP Code
Therapist (Speech/OT/PT)			
Street Address	City	State	ZIP Code

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

2. **To Disclose Information To and Exchange Information With People or Organizations Identified Below:**

School/Special Education Unit			
Street Address	City	State	ZIP Code
Parent: (if client is 18 years of age or older)			
Street Address	City	State	ZIP Code
Regional Human Service Center			
Street Address	City	State	ZIP Code
Other			
Street Address	City	State	ZIP Code

3. The Following Information May Be Requested or Exchanged:
   Information determined necessary for prompt and accurate diagnosis, treatment and follow-up care including, but not limited to, team reports, office notes, progress reports, hospital discharge summaries, lab and x-ray results or other diagnostic studies.
4. The Information Identified Above Will Be Used For The Following:
   Eligibility Determination **Treatment Planning**
   Claims Payment **Care Coordination/Follow-up Activities**
5. I understand the information to be released may include my past, present, or future health information.
   This authorization will not expire unless revoked in writing by you or your legal representative. I understand there is a potential that information disclosed pursuant to the authorization is subject to redisclosure by the recipient and no longer protected by HIPAA.
6. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form, including oral, written, or electronic transmission.
7. Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this application are intended to authenticate this writing and to have the same force and effect as handwritten signatures.

CLIENT AUTHORIZATION

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original.

Signature of Client (if 18 years of age or older)		Date
Signature of Parent/Guardian or Custodian (if needed)	Relationship	Date
Signature of Witness (if needed)		Date

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification; failure to disclose this information will not affect the disclosure of information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department 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 Department health plan.

DISTRIBUTION:
- ☐ To agency/person from whom information is sought
- ☐ Requesting Agency
- ☐ Client
- ☐ Other (specify): _____

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE