AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1059 (5-2023)

Clear Fields

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 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.

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 (ONLY if email delivery is requested)		Telephone Number
Street Address	City	State	ZIP Code

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

Name of Person/Agency	Email Address (ONLY if email delivery is requested)		Telephone Number
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 Department'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

NOTICE TO RECIPIENTS OF SUBSTANCE USE DISORDER RECORDS: The federal regulations governing the Confidentiality of Substance Use Disorder records, 42 C.F. R. Part 2, prohibits unauthorized disclosure of these records.

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

Instructions for Department of Health and Human Services
Authorization to Disclose Information Form SFN 1059

Individual's full/complete name. If there is a suffix after the name (Sr., Jr.), please provide it in the space along with the last name.

Previous name(s) used by the individual.

Individual's date of birth.

Individual's Social Security Number. Disclosure of a social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose social security number will not affect the disclosure of other information. The Department will not condition treatment on an individual's agreement to authorize disclosure of health information. The Department may, however, require an individual authorize the disclosure of health information if needed to make a determination about an individual's eligibility for benefits or enrollment in a Department health plan.

Individual's full/complete address.

Section 1: The name or other specific identification of the person, agency or class of persons, authorized to disclose the information, telephone number and complete mailing address. Provide an Email address if Email delivery is requested.

Section 2: The name or other specific identification of the person, agency or class of persons authorized to receive the information, telephone number and complete mailing address. Provide an Email address if Email delivery is requested.

Special Information Regarding Email Delivery: The Department is committed to safeguarding information in transit. Protected health information, confidential information and client specific information will only be sent by secure Email to persons/agencies outside the Department.

Section 3: Provide a detailed description of the information to be disclosed, including how much and what kind of information. If the information is limited to specific date(s), please include this information. Statements such as “All my information” or “My entire record” are acceptable.

Special Attention: There are certain types of information that require special authorization.

- Substance Use Disorder (drug or alcohol) information comes from a program or provider that specifically assesses and treats substance use disorders and receives federal funding. Substance use disorder information subject to this authorization must be specifically described. Statements such as “All my substance use disorder information” and “None of my substance use disorder information” are acceptable.
- Psychotherapy notes are kept by a mental health professional separate from other information. The disclosure of psychotherapy notes requires a separate authorization form. The name of the professional who may disclose the psychotherapy notes must be identified on the form.

Section 4: Select the reason(s) why the information is being disclosed.

Section 5: Using MM/DD/YYYY format, enter the date the authorization is to expire. If left blank, the authorization will expire one year from the date it is signed.

Client Consent: Sign and date the form. The Department may request individuals provide proper identification. If you are a legal representative, sign, date and indicate your relationship to the individual.

- **Please note:** If the form is signed by a legal representative such as a guardian or custodial agency, a copy of the legal documents verifying the legal representative's authority must be on file with the Department or attached to this form.

- **Minors:** North Dakota law requires a minor 14 years of age or older, to authorize the disclosure of sexually transmitted disease and substance use disorder treatment information. Disclosure of sexually transmitted disease or substance use disorder treatment information of a minor 13 years of age or younger, must be authorized by BOTH the minor and the parent/legal guardian.