ADULTS ADOPTING SPECIAL KIDS PROGRAM (AASK)
AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES-ADOPTIONS
SFN 921 (1-2025)

Clear Fields

AASK Contact Name		AASK Agency Telephone Number	
AASK Agency Address	City	State	ZIP Code

This form is used by authorized agents to permit the disclosure of records and information to the AASK Program for adoption purposes.

Directions authorized agent: Complete and sign the form. Retain a copy in the child's case record. Return the completed form along with a copy of the current court order indicating your authority to act on behalf of the child to the above AASK location.

* In compliance with the Federal Privacy Act of 1974, disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

CHILD'S RECORDS TO BE DISCLOSED

Child's Name (Last, First, Middle)	Social Security Number*	Date of Birth
Other Names Used		

RELEASE INFORMATION FROM

Facility Name			
Facility Address	City	State	ZIP Code

RELEASE INFORMATION TO

Adults Adopting Special Kids (AASK) *Includes all AASK locations*
Fax: 701-356-7993

- ☐ 5201 Bishops Blvd S, Suite B, Fargo, ND 58104 • 701-235-4457 • Email address: _____
- ☐ 600 S. 2nd St., Suite 150, Bismarck, ND 58504 • 701-255-1793 • Email address: _____
- ☐ 311 4th St. S, Suite 105, Grand Forks, ND 58201 • 701-775-4196 • Email address: _____
- ☐ 216 S. Broadway, Suite 202, Minot, ND 58701 • 701-852-2854 • Email address: _____

SERVICE DATES

From: _____ To: _____ **and all future records until authorization expires.**

I authorize:

- All medical sources including but not limited to hospitals, clinics, occupational therapy, physical therapy, optometrists, dentists, and labs.
- All Behavioral Health sources including but not limited to mental health, psychological, psychiatric, and substance use disorder;
- All Development, Education and Vocational sources including but not limited to schools, special education, teachers, administrators and counselors, speech therapists, Developmental Disability service providers, and Vocational Rehabilitation; and
- Foster care personnel and providers.

To mutually exchange with the AASK Program, the following information:

- All medical and treatment records including but not limited to: Preventive, diagnostic, therapeutic, rehabilitative, and counseling, service, birth records, assessment, or procedure with respect to the physical or mental condition, or functional status, of the above name child;
- All substance use disorder records of the above-named child;
- All education records;
- All Court orders, records, and reports;
- Foster care case plans, goals and progress, family history, and progress in the foster home.

The information will be used for adoption purposes.

Authorization remains in effect for one year from date of signature, unless otherwise specified: (MM/DD/YYYY):

This authorization is voluntary. Your authorization or refusal to authorize disclosure of personal health information will have no effect on your treatment, payment, enrollment, or eligibility for benefits.

This authorization remains in effect until the expiration date unless specifically revoked. You have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. To revoke, send a written statement to the AASK location above. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photocopy 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.

Authorized Agency Name		Telephone Number	
Agency Address	City	State	ZIP Code
Printed Name of Authorized Agent	Title		
Signature of Authorized Agent		Date	
Signature of Child (if required)		Date	