AUTHORIZATION TO DISCLOSE BEHAVIORAL HEALTH INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1063 (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.

The Department of Health and Human Services' public behavioral health system is comprised of the facilities listed below and is collectively referred to as Field Services.

☐ Northwest Human Service Center	316 2nd Ave W, Williston, ND 58802	Telephone: 701-774-4600
☐ North Central Human Service Center	1015 S Broadway, Ste 18, Minot, ND 58701	Telephone: 701-857-8500
☐ Lake Region Human Service Center	200 Hwy 2 W, Devils Lake, ND 58301	Telephone: 701-665-2200
☐ Northeast Human Service Center	151 S 4th St, Suite 401, Grand Forks, ND 58201	Telephone: 701-795-3000
☐ Southeast Human Service Center	2624 9th Ave S, Fargo, ND 58103	Telephone: 701-298-4500
☐ South Central Human Service Center	520 3rd St NW, Jamestown, ND 58401	Telephone: 701-253-6300
☐ West Central Human Service Center	1237 W Divide Ave, Ste. 5, Bismarck, ND 58501	Telephone: 701-328-8888
☐ Badlands Human Service Center	1463 I-94 Business Loop E, Dickinson, ND 58601	Telephone: 701-227-7500
☐ State Hospital	2605 Circle Drive, Jamestown, ND 58401	Telephone: 701-253-3650
☐ Life Skills and Transition Center	816 W Midway Drive, Grafton, ND 58237	Telephone: 701-352-4200

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

I AUTHORIZE (check one): ☐ Field Services OR ☐ the Facility or Facilities Selected Above

TO (check one): ☐ Disclose To ☐ Obtain From ☐ Mutually Exchange With

Name of Person/Agency		Telephone Number	
Street Address	City	State	ZIP Code

SERVICE DATES: From: To: If service dates are not specified, the last documented information pertaining to the selected or identified will be disclosed.

INSTRUCTIONS: Select the information to be disclosed in Section 1 OR describe the information to be disclosed in Section 2. Section 2 may also be used to provide additional instructions or information. Section 3 must be completed if Substance Use Disorder information is included in the disclosure. Information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission unless otherwise specified in Section 2.

1. Information to Be Disclosed (check all that apply):

☐ Integrated Assessment ☐ Psychological Evaluation ☐ Urine Drug Screen Results
☐ Diagnostic/Psychiatric Assessment ☐ Medical Notes ☐ Xray Reports
☐ Integrated Treatment/Service Plan ☐ Medication List ☐ Service and Discharge Summary
☐ Progress Notes ☐ Lab Results
☐ Other (specify): _____
☐ Letter with (check all that apply): ☐ Treatment/Service Dates ☐ Diagnosis ☐ Treatment/Service Recommendations

2. Provide a detailed description of the information to be disclosed, including how much and what kind of information. This section may also be used to provide additional information or instructions.

3. Substance Use Disorder Information. Complete this section if you want to authorize the disclosure of Substance Use Disorder information. If this Section is not completed, Substance Use Disorder information may not be disclosed.

☐ Disclose my Substance Use Disorder information contained in the information specified in this authorization.

NOTICE TO RECIPIENT: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

The Information is to be Used For (check 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): _____

THIS AUTHORIZATION REMAINS IN EFFECT FOR ONE YEAR FROM THE DATE SIGNED UNLESS A DIFFERENT EXPIRATION DATE IS ENTERED HERE:

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 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 the 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.

MINORS SUBSTANCE USE DISORDER INFORMATION 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 are required to authorize the disclosure of Substance Use Disorder information, including disclosures to the minor's legal representative.

Signature of Client		Date
Signature of Parent/Legal Representative (if applicable)	Relationship	Date
Signature of Witness (if needed)		Date

DISTRIBUTION: ☐ Person/Agency ☐ Client ☐ Client Refused Copy

Instructions for Department of Health and Human Services Behavioral Health Authorization to Disclose Information Form SFN 1063

Please contact one of the facilities listed on the form if you have any questions or would like assistance in completing the form.

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.

Select "Field Services" (all facilities) **or "the Facility or Facilities Selected Above".** Be sure the Facility or Facilities have been selected above if applicable.

Select one, "Disclose To", "Obtain From", or "Mutually Exchange With".

Name of Person/Agency or other specific identification of the person, agency, or class of persons authorized to receive the information. Include the complete mailing address, if available.

Enter the specific dates or date range of the information to be disclosed. If service dates are not specified, the last documented information pertaining to the selected or identified will be disclosed.

Information To Be Disclosed. Select the information to be disclosed in section #1 OR describe in great detail the information to be disclosed in Section #2. Statements such as "All my information" or "My entire record" are acceptable in Section #2 however, please be aware there may be fees associated with record requests.

Substance Use Disorder Information. All Field Service Facilities assess and treat substance use disorders (drug and alcohol) and are subject to the federal law governing the confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. part 2. If this section is not completed, substance use disorder treatment information may not be disclosed.

There are certain types of information that require special authorization. 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.

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

Enter the date the authorization will expire using MM/DD/YYYY format. If left blank, the authorization will expire one year from the date it is signed. Do not enter an expiration event.

The form must be signed and dated by the individual or their legal representative, if applicable.

A legal representative is a person or entity that has authority under an applicable law, to act on behalf of the individual. The legal representative must also include their relationship to the client. A copy of the legal document verifying the legal representative's authority (guardian, custodian, etc.,) must be on file with the Department or attached to this form.

In accordance with North Dakota law, a minor 13 years of age or younger and the minor's legal representative must sign this form permitting the disclosure of sexually transmitted disease or substance use disorder treatment information. A minor 14 years of age or older must sign this form permitting the disclosure of sexually transmitted disease or substance use disorder treatment information (only the minor).