AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF REFUGEE SUPPORT SERVICES
SFN 1065 (5-2024)

Clear Fields

* Disclosure of the alien number is voluntary and is requested for the purpose of accurate identification. Failure to disclose the alien 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 the Client (Last, First, Middle Initial)	Alien Number*	Date of Birth	
Street Address	City	State	ZIP Code

I AUTHORIZE:

The Office of Refugee Support Services
600 E. Boulevard Ave, Dept 325
Bismarck ND 58505

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

The below persons/agencies for the purpose of determining eligibility for and coordination of Refugee Cash and Medical Assistance and Refugee Support Services.

FROM WHOM

- All medical sources (public health agencies, VA healthcare facilities, hospitals, clinics, labs, physicians, etc.), behavioral health (mental health and substance use disorder) facilities and providers, and correctional health care facilities and providers.
- All educational sources (schools, special education units, teachers, records administrators, counselors, etc.).
- Social workers, rehabilitation counselors, and case managers.
- Economic assistance program agencies, non-profit agencies, rental agencies and childcare providers.
- Social Security Administration, US Citizenship and Immigration Services, and resettlement agencies.
- Employers, career navigation services, training and skill development services, and Workers' compensation programs.

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

☐ Proof of Residency	☐ Education/Academic Assessments	☐ DS-3025-Vaccination
☐ Immigration/Legal Status Documents	☐ Academic Progress Reports	☐ DS-3026- Medical History
☐ Eligibility Determination	☐ Vocational Testing/Assessments	☐ DS-3030-TB Worksheet
☐ Refugee Cash Assistance	☐ Individualized Family Service Plans	☐ Pre-Departure Screening Form
☐ Household Income	☐ Individual Plan for Employment	☐ Significant Medical Conditions Form
☐ Wages and Dates of Employment	☐ Individualized Service Plans	☐ Medical Screening Assessment
☐ School Enrollment Date	☐ DS-2054 Medical Exam	☐ Progress/Provider Notes

☐ Other (must be specified to be valid): _____

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.

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