AUTHORIZATION FOR RELEASE OF INFORMATION
SPIRIT LAKE VOCATIONAL REHABILITATION PROGRAM
P.O. Box 519, Ft. Totten, ND 58335

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.

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client (Last, First, Middle Initial)	Social Security No.	Birth Date	
Street Address	City	State	Zip Code

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize: (Name and Address of Person/Agency)

2. To Release Information to (Name and Address of Person/Agency to Receive Information)
   Spirit Lake Vocational Rehabilitation Program
   P.O. Box 519
   Ft. Totten, ND 58335

3. The Following Information is Requested:
   _____ Current Medical Information To Include Diagnosis, Prognosis, Vocational Limitations, and if Available, Current Lab Work.
   _____ Addiction Evaluation and Treatment Plan, Dates Client Entered and Completed Treatment, If Available and Treatment or Discharge Summary.
   _____ Psychological Evaluation and Treatment Plan, and if Available, Treatment or Discharge Summary.
   _____ Other

4. The Information Identified Above Will Be Used For:

   To Determine Eligibility For Vocational Rehabilitation Services and To Provide Services To The Client.

5. This release of Information consent remains in effect until _____ (Date)
   Or Specific Event Terminating Ooperation of the Release:

CLIENT CONSENT:
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. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original.

Signature of Client	Date
Signature of Parent/Guardian or Custodian (if needed)	Date
Signature of Witness (if needed)	Date

☐ Check if Applicable - **NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION:
ORIGINAL - To agency / person from whom information is sought
CANARY - Requesting Agency
PINK - Client