Minnesota Recovery Connection
Standard Authorization to Disclose Protected Health Information

I, _____ DOB:_____, authorize **Minnesota Recovery Connection** to use, disclose, receive and/or exchange certain of my protected health information with:

Name of Organization or Individual: _____

Phone: _____ **Fax or Email:** _____

The protected health information to be used or disclosed is limited to the following information:

_____ Medical	____ Educational	____ Progress Notes/Reports	____ Discharge Summary
____ Legal	____ Substance Use	____ Recovery Plan	
____ Financial	____ Psychological	____ Diagnostic Information	Other: _____

Purpose of Disclosure: _____

Persons Authorized to Release or Receive Information: _____

Expiration of Authorization:

This consent will expire on _____ or **one (1) year** from the date signed, whichever occurs first.

Participant Rights and Notices:

- I understand that my records are protected under federal regulations (42 CFR Part 2 and HIPAA) governing the confidentiality of substance use disorder treatment records.
- I may revoke this authorization at any time by providing written notice to Minnesota Recovery Connection, except to the extent that action has already been taken in reliance on it.
- I understand that refusal to sign this authorization may limit MRC's ability to coordinate my care or provide certain services, but will not affect my right to receive other services.
- I understand that I am entitled to a copy of this authorization once it has been signed.

Prohibition on Redisclosure (Required by 42 CFR Part 2):

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.

Authorization and Signature:

Participant Signature: _____ **Date:** _____

Participant Printed Name: _____

A copy of this authorization is as valid as the original bearing my signature.