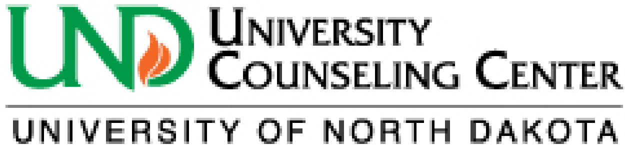

University Counseling Center
McCannel Hall, Room 200
2891 2nd Avenue N., Stop 9042
Grand Forks, ND 58202-9042
Phone: 701.777.2127 Fax: 701.777.4189

Authorization for Release of Information (ROI)-Behavioral Health and/or Substance Use

_______________________________________ **Legal Name of Client (Last, First, MI)**

_______________________________________ **Address**

______________________ **Telephone**

_____/_____/_____ **Date of Birth**

______________________ **City** **State** **Zip**

The above-named individual authorizes the UND University Counseling Center to exchange, release and/or receive, as described below, confidential information to/from:

_______________________________________ **Name/Organization**

_______________________________________ **Address**

______________________ **Telephone**

______________________ **Fax**

______________________ **City** **State** **Zip**

Information to be disclosed between entities listed (*Circle Yes/No for Each):*

Yes No Acknowledgement of Client's Access of Service
Yes No Any Information Pertinent to Treatment or Plan
Yes No Intake Assessment and Diagnosis
Yes No Alcohol and Drug Evaluation
Yes No Treatment Plans/Recommendations
Yes No Progress in Treatment
Yes No Psychological/Psychiatric Consults
Yes No Termination Summary/Planning
Yes No Other: ___________________________

I authorize *(Select One):*

- ☐ The release of all pertintent chart records selected above.
- ☐ The release of all pertinent chart records selected above, for the specific record date range of: ______________________

This release is valid for one year from the date signed. Note: this authorizaiton, except for action alredy taken, can be revoked by me at anytime.

Purpose: The purpose of this release is to facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the above UND entity for evaluation/treatment services.

Other: ____

Information may be communicated verbally, in writing, and/or by facsimile. Please do not use email, as confidentiality cannot be assured.

Notice:

- I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above.
- Further disclosure of confidential information without the specific written consent of the person to whom it pertains is prohibited by state and federal laws. I understand that information in confidential records cannot be released without my written consent unless otherwise provided in state and federal laws and court orders.
- 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 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 and 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.
- I understand that in the event I am authorizing the disclosure of my treatment information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law.
- I understand that I am entitled to a copy of this Authorization for Release of Information (ROI), upon request.
- A photocopy of reproduction of this document is as valid as the original.

My signature below indicates that I understand the conditions of this release and that I give my authorization voluntarily. By signing this form, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature.

Client Name: ____ **Student ID#:** ______________________

Client Signature: _____________________________________ **Date:** ____________________________