The Kid's Therapy Center LLC
1701 S 12th ST
Bismarck, ND 58504
(701)751-0384

Name of Patient _____ Date of Birth _____

I authorize _____ to release to:
(Name of Individual or Organization to Release Information)

_____
(Name of Individual or Organization to Release Information)

and/or

I authorize _____ to release to:
(Name of Individual or Organization to Release Information)

_____
(Name of Individual or Organization to Release Information)

I am requesting and authorizing the release of the following mental health information (This authorization is voluntary):
____ Two-way Ongoing Written (incl. email) ____ Two-way Ongoing Verbal (incl. email) ____Electronic Protected Health Information

I am requesting and authorizing the release of the above information for the following purpose:
____ Diagnosis & Treatment ____ Legal Investigation ____ Insurance Purposes ____ Personal ____Specify other

____ If my child is 14 years or older I understand the ND Century Code: 14-10-17. (Minors-Treatment for sexually transmitted disease-Drug abuse-Alcoholism) does not need permission, authority, or consent of a guardian for treatment.

This authorization will remain effective until the following date, event or condition: _____
If no date, event or condition is specified, this authorization will expire in one year.

1. This authorization remains in effect until the above date, event condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be disclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

_____ Date: _____
(Signature of Client)

_____ Date: _____
(Signature of Legal Guardian or Legal Representative) (Relationship)

_____ Date: _____
(Signature of Witness)

☐ **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 rule prohibits 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 pertain 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