Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

THIRD-PARTY AUTHORIZATION AND RELEASE OF PATIENT INFORMATION

Confidential Patient Information – HIPAA Privacy Protected

Purpose: This form authorizes an outside healthcare provider or third party to disclose a patient's protected health information to Northwest Open Arm Mental Health for treatment coordination, psychiatric evaluation, medication management, and continuity of care.

1. Patient Information

Patient's Full Legal Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City, State, ZIP: _____

Email: _____

2. Third-Party Provider / Organization Releasing Information

Provider / Organization Name: _____

Contact Person: _____

Address: _____

City, State, ZIP: _____

Telephone: _____ Fax Number: _____

Email: _____

3. Recipient of Information

Northwest Open Arm Mental Health
941 Hillwind Rd NE, Suite 205, Fridley, MN 55432
Telephone: 763-703-6686 Fax: 763-342-0971 / 763-402-7619
Website: www.nwopenarm.com

4. Information Authorized for Release

Please check all applicable records:

- ☐ Psychiatric evaluation and diagnostic assessment
- ☐ Medical history and physical examination
- ☐ Mental health treatment records
- ☐ Psychiatric progress notes
- ☐ Medication history and medication management records
- ☐ Current and previous medication lists
- ☐ Psychological testing and assessment results

☐ Laboratory and diagnostic results
☐ Hospitalization and discharge summaries
☐ Treatment plans and recommendations
☐ Other: _____

Specially protected records (initial to include):

_____ Substance use disorder treatment records (a separate consent that meets federal confidentiality rules, 42 CFR Part 2, may be required).

_____ Other specially protected records (for example, HIV/STI test results or genetic information): _____

Date range of records requested:

From: _____ To: _____

5. Purpose of Information Release

☐ Coordination of psychiatric care
☐ Initial psychiatric evaluation
☐ Medication management
☐ Continuity of treatment
☐ Transfer of care
☐ Other: _____

6. Patient Authorization and Consent

I authorize the third-party provider or organization identified above to disclose and release the selected health information to Northwest Open Arm Mental Health.

I understand that:

1. Signing this authorization is voluntary.
2. I may revoke this authorization at any time by giving written notice to the provider or organization named in Section 2, or to Northwest Open Arm Mental Health at the address or fax number in Section 3. The clinic's Notice of Privacy Practices explains how to revoke. A revocation does not apply to action already taken in reliance on this authorization.
3. Information disclosed may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.
4. My treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization, except where permitted by law.
5. I am entitled to receive a copy of this signed authorization.
6. This authorization does not include psychotherapy notes or other specially protected records unless I have separately initialed or consented above.

Expiration date or event (required): _____

7. Signatures

Patient / Authorized Representative Signature: _____ Date: _____

Print Name: _____

If signed by a representative, relationship to patient: _____

Representative's legal authority (for example, guardian or power of attorney): _____

Witness / Staff (optional) signature: _____ Date: _____ Print: _____