Authorization for Release of Clinically Related Information
Dakota Boys and Girls Ranch

Fargo Residential Center	Fargo Youth Home	Western Plains	Minot Campus
7151 15th St S.	1641 31st Ave. S.	1227 35th St. N.	PO Box 5007
Fargo, ND 58104	Fargo, ND 58103	Bismarck, ND 58501	Minot, ND 58702-5007

Client Name: _____ Date of Birth: _____

Authorization is hereby granted to Dakota Boys and Girls Ranch
P.O. Box 5007
Minot, ND 58702-5007
to release/obtain the following information:

____ Psychiatric evaluation(s)
____ Intake summary (ies)
____ Progress report(s)
____ CD assessment and recommendation
____ Transcripts
____ Court order
____ History and physical
____Individual Treatment Plan
____ Psychological evaluation(s)
____ Discharge summary (ies)
____ History of Alcohol/Drug use and behavior
____ IEP and/or 504 plan
____ Educational assessments/evaluations
____ Legal status
____ Lab results (including drug/alcohol)
____ Other (specify) _____

To: _____
_____

I authorize the mutual release of information between the above mentioned parties Yes___ No___

For the purpose of:

____ Diagnosis/Treatment
____ Updating Records
____ Family Program Participation
____ Continuity of Care
____ Other (please specify): _____
____ Aftercare Treatment
____ Coordinating Treatment
____ Assessment/Evaluation
____ Acknowledgement of Referral

Information may be communicated: ___ verbally ___ written ___fax ___ other electronic means

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could not be re-disclosed.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that his authorization will expire on: _____ or if no date or event is specified, 12 months from date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian (when required) Date

_____ _____
Legal Custodian Date

_____ _____
Witness Date

NOTICE TO WHOMEVER DISCLOSURE IS MADE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42-CFR PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIED WRITTEN CONSENT OF THE PERSON WHOM IT PERTAINS OR OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

Revised 8-22-05