MULTI-PARTY AUTHORIZATION TO DISCLOSE INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 970 (9-2023)

Clear Fields

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose the social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

This form is used by the Department to facilitate disclosure among and between the Department and multiple parties who share the common purpose of providing and coordinating treatment and services, and who have a legitimate need for the same kind and amount of information.

Name of Client (Last, First, Middle Initial)	Social Security Number	Date of Birth	
Previous Names Used			
Street Address	City	State	ZIP Code

I authorize the disclosure of the information selected in Section 1 or described in Section 2, among and between the below parties:

1. Name of Person/Entity Special Health Services	Telephone Number (701) 328-4816		2. Name of Person/Entity	Telephone Number	
Address 600 E Blvd Ave, Dept 325			Address		
City Bismarck	State ND	ZIP Code 58505	City	State	ZIP Code
3. Name of Person/Entity	Telephone Number		4. Name of Person/Entity	Telephone Number	
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
5. Name of Person/Entity	Telephone Number		6. Name of Person/Entity	Telephone Number	
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
7. Name of Person/Entity	Telephone Number		8. Name of Person/Entity	Telephone Number	
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
9. Name of Person/Entity	Telephone Number		10. Name of Person/Entity	Telephone Number	
Address			Address		
City	State	ZIP Code	City	State	ZIP Code

INSTRUCTIONS: Select the information to be disclosed in Section 1 OR describe the information to disclosed in Section 2. Section 2 may also be used to provide additional instructions or information. Section 3 must be completed if Substance Use Disorder information is included in the disclosure. Information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission unless otherwise specified in Section 2.

1. Information to Be Disclosed (check all that apply):

Behavioral Health

☐ Assessments	☐ Treatment Plans	☐ Medication Records
☐ Psychiatric Evaluations	☐ Treatment Recommendations	☐ Urine Drug Screen Results
☐ Psychological Evaluations	☐ Diagnosis	☐ Treatment/Service Dates
☐ Neuropsychological Evaluations	☐ Progress/Provider Notes	☐ Discharge Summaries

Medical

☒ History/Physical Exams	☒ Treatment & Care Plans	☐ TB Test Results
☐ Physical Therapy Assessments	☒ Progress/Provider Notes	☐ Medical Imaging Reports (X-rays, MRIs)
☐ Occupational Therapy Assessments	☐ Medication Records	☐ Allergies
☒ Diagnosis and Conditions	☐ Lab Results (urine/blood)	☐ Discharge Summaries

Development/Academic Assessments

☐ Education/Academic Assessments	☐ Vision/Eye Assessments	☐ Individual Education/504 Plans
☐ Vocational Testing/Assessments	☒ Diagnosis and Conditions	☐ Transition Plans
☐ Functional/Behavioral Assessments	☒ Treatment/Service Recommendations	☐ Individualized Service Plans
☐ Developmental Assessments	☐ Treatment/Service Dates	☐ Individualized Family Service Plans
☐ Early Intervention Assessments	☒ Progress/Provider Notes	☐ Behavior Intervention Plans
☐ Speech/Language Assessments	☐ Discharge Summaries	☐ Individual Plan for Employment
☐ Hearing Assessments		

2. Provide a detailed description of the information to be disclosed, including how much and what kind of information. This section may also be used to provide additional information or instructions.

3. **Substance Use Disorder Information**. Complete this section if you want to authorize the disclosure of Substance Use Disorder information. **If this Section is not completed, Substance Use Disorder information may not be disclosed.**

☐ Disclose my Substance Use Disorder information contained in the information specified in this authorization.

NOTICE TO RECIPIENT: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at\ §§ 2.12(c)(5) and 2.65.

I understand the purpose of the disclosure among and between the parties is to provide and coordinate my treatment or services. I understand the parties will communicate with and disclose to one another the information I designated above. To limit disclosure to only certain parties or certain information, I must use a separate authorization form.

THIS AUTHORIZATION REMAINS IN EFFECT FOR ONE YEAR FROM THE DATE SIGNED UNLESS A DIFFERENT EXPIRATION DATE IS ENTERED HERE:	

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice at any time, except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photocopy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

MINORS SUBSTANCE USE DISORDER INFORMATION In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose Substance Use Disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative are required to authorize the disclosure of Substance Use Disorder information, including disclosures to the minor's legal representative.

Signature of Client		Date
Signature of Parent/Legal Representative (if applicable)	Relationship	Date
Signature of Witness (if needed)		Date

DISTRIBUTION: ☒ Person/Entity ☒ Client ☐ Client Refused Copy

Instructions for Department of Health and Human Services
Multi-Party Authorization to Disclose Information (SFN 970)

Note: The SFN 970 is used by the Department to facilitate disclosure among and between the Department and multiple parties who share the common purpose of providing and coordinating treatment and services, and who have a legitimate need for the same kind and amount of information.

Individual's full/complete name. If there is a suffix after the name (Sr., Jr.), please provide it in the space along with the last name.

Previous name(s) used by the individual. Individual's date of birth.

Individual's Social Security Number. Disclosure of a social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose social security number will not affect the disclosure of other information. The Department will not condition treatment on an individual's agreement to authorize disclosure of health information. The Department may, however, require an individual authorize the disclosure of health information if needed to make a determination about an individual's eligibility for benefits or enrollment in a Department health plan.

Individual's full/complete address.

Name of Person/Entity. The name of the person(s) or Entity(ies) and complete mailing address, authorized to receive and disclose the information.

Information To Be Disclosed. Select the information to be disclosed in Section #1 OR describe in great detail the information to be disclosed in Section #2. Statements such as “All my information” or “My entire record” are acceptable in Section #2 however, please be aware there may be fees associated with record requests.

Substance Use Disorder Information. Substance Use Disorder Patient Records are confidential under federal law, 42 C.F.R. part 2. If this section is not completed, substance use disorder treatment information may not be disclosed.

There are certain types of information that require special authorization. Psychotherapy notes are kept by a mental health professional separate from other information. The disclosure of psychotherapy notes requires a separate authorization form. The name of the professional, who may disclose the psychotherapy notes must be identified on the form.

Enter the date the authorization will expire using MM/DD/YYYY format. If left blank, the authorization will expire one year from the date it is signed. Do not enter an expiration event.

The form must be signed and dated by the individual or their legal representative, if applicable.
A legal representative is a person or entity that has authority under an applicable law, to act on behalf of the individual. The legal representative must also include their relationship to the client. A copy of the legal document verifying the legal representative's authority (guardian, custodian, etc.,) must be on file with the Department or attached to this form.
In accordance with North Dakota law, a minor 13 years of age or younger and the minor's legal representative must sign this form permitting the disclosure of sexually transmitted disease or substance use disorder treatment information. A minor 14 years of age or older must sign this form permitting the disclosure of sexually transmitted disease or substance use disorder treatment information (only the minor).