ShareHouse

Referral for Substance Use Disorder Assessment

Clients First and Last Name: _____ Date of Birth: _____

Phone number: _____ Address: _____

Insurance: _____ MN / ND ☐ Uninsured

Referal Name/Facility: _____

Date Last Seen/Evaluated: _____

Withdrawal Risk (If known): ☐ Low ☐ Moderate ☐ High

Summary of client needs:

(Turn over)

SHAREHOUSE
Recovery is possible.

Release of Information (ROI)

I authorize _____and ShareHouse, Inc. to exchange the information on this form for the purpose of assessment, treatment and care coordination. This consent is valid for one year from the date it is signed, except as otherwise allowed by statute.

CLIENT CONSENT:

I have been told and understand that I am authorizing my health information as specified above to be released for the purposes specified. I understand that, as it relates to alcohol and drugs issues, it is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws. I understand that information being shared may include information such as medical, psychiatric/psychological, and/or HIV information. Disclosure, including re-disclosure, is allowed only with my authorization except in limited circumstances described in the ShareHouse, Inc. Privacy Notice. However, HIPAA requires ShareHouse, Inc. to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. I also understand that communications resulting from this authorization will reveal that I receive services at ShareHouse, Inc. and/or Essentia Health.

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization through verbal, written, or electronic transmission. I understand that ShareHouse, Inc. may deny me services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Client Signature: _____ Date:_____

CC: ☒ Client ☒ Chart ☒ Recipient

Please scan and email to admissions@sharehouse.org Fax Number: 651-925-0046 Call: 701-936-3656

The walk-in assessment clinic is located at 505 40th St S. Fargo 58103

Hours are 8AM-2:30pm Monday- Thursday & Fridays 8AM-1:30pm

For information on programs and processes at sharehouse please visit

Sharehouse.org

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