AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

I, _____ (DOB: _____), authorize
(Name/Date of Birth of individual authorizing release or exchange)

NICOLLET COUNTY OFFICE OF HEALTH AND HUMAN SERVICES (hereinafter "Agency")

and _____ to release or exchange private data about me.
(Name of individuals or entity)

Release or exchange the following information:

☒	Discharge or Closing Summary	☒	Treatment Plan or Community Support Plan
☒	Medical History Records	☐	Birth Records
☒	Social Services Records	☐	School Records, IEP, Assessment, Transcripts
☒	Progress Reports	☐	Immunization Records
☒	Treatment Records	☐	Vocational Reports
☒	Court Records	☒	Admission/Intake Summary/Diagnostic Assessment
☒	Psychiatric Evaluation	☒	Social History
☒	Psychological Testing or Evaluation	☒	Laboratory Reports (List Below)
☐	Other (List) _____		

The follow information requires special consent by law. You must specifically request the follow information in order for it to be released or exchanged:

☒ Chemical Dependency Program Records

☒ Psychotherapy Notes (this consent cannot be combined with any other and must be on its own form)

The information is required to:

☒	Continue evaluation or treatment	☒	Determine eligibility for case management services
☒	Coordinate services	☐	Other (List) _____

By indicating any of the information above, you are giving permission for written information to be released or exchanged, and for the individuals or entities indicated above to talk about the information indicated above. If you do not want to give your consent for the individuals or entities indicated above to talk about the information indicated above, indicate that here (check mark or initials) _____

I understand:

- Why I am being asked for this information.
- State and Federal privacy laws protect my records. My records can be released or exchanged only if I give my written permission or if the law allows it.
- If I refuse to sign or cancel this authorization, I may not be eligible to receive the service(s) I am requesting.
- I may cancel this authorization with WRITTEN NOTICE at any time, but that this written notice will NOT affect information the Agency has already released or exchanged.
- Those who receive my records under this authorization may be able to share it with others.
- Once the information is released to or exchanged with others, it is no longer protected by this authorization.

This authorization ends _____, or one (1) year from the date I sign it, or other periods as provided by law.

_____ _____
Signature of individual authorizing release or exchange of information Date

_____ _____
Signature and relationship of parent, guardian, or authorized representative (if required) Date

NOTE TO AGENCIES USING THIS FORM: The consequences of giving informed consent must be communicated to the individual prior to signing his/her signature. The individual who consents to release or exchange of personal information must be provided a signed (executed) copy of the authorization.

This information is available in other forms to people with disabilities by calling your county worker. For TTY/TDD users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For Speech Relay call (877) 627-3848.