Clear Form

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

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

I authorize the ☐ release or ☐ exchange of the following written information for the time period of:

_____

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

Specify document type _____

Other (List) _____

The following information requires special consent by law. You must specifically request the following 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
☐ Coordinate services
☐ Determine eligibility for case management services
☐ Other (List) _____

Verbal release or exchange
By indicating any of the information above, you are giving permission for *written* information to be released or exchanged. Indicate here your consent for the individuals or entities indicated above to *verbally* communicate about information selected above.

☐ I give consent for the individuals or entities indicated above to talk about the information checked above.
☐ I **do not** give consent for the individuals or entities indicated above to talk about the information checked above.

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 in the hands of the recipient.

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.