Health and Human Services
602 East Fourth Street
Chaska, MN 55318-2102
Phone (952) 361-1600
Fax (952) 361-1660

CARVER COUNTY

RELEASE OF INFORMATION

I, _____ (Name of Individual),

hereby authorize **Carver County** to disclose to and/or exchange with

_____ (Person or Organization to which disclosure is to be made)

regarding: _____ DOB:

Completely cross out areas you do not want released.

	Initial Intake			Status Reports			Individualized Education Plan
	Diagnostic Assessment			Family Assessment			FSE Summaries & Reports
	Admission Summary			Progress Reports/Notes			CDCS or CSG Budgets
	Medication Records			MnCHOICES Assessment/Results			Social Security Reports/Benefits
	Laboratory Reports			Behavior Plan			Physical Exam
	Treatment Plan			Discharge Summary			Social History
	Psychological Evaluations			Financial Application and Eligibility Information			Individual Care Service Plan(s)
	Case Management Records			School Records and Reports			Provider Service Plan(s)
	Physicians Orders			Vocational Assessment			

The following information requires special consent by law. Even if you indicate all mental and physical information to be released, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program/provider treatment records (applies to formal CD treatment only)

If you want only specific dates/years of your treatment records released, please list: _____

Other records to be released: _____

Records are to be released for the following purpose: **Assessment or Coordination of Services**

I understand that I do not have to consent to the release of this information. I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time in writing and that in any event this consent expires automatically as described below. If I choose to revoke this consent it will not affect information already released. I understand that information maintained by the organization named above is limited to staff whose work assignments reasonably require access to such information within the purposes specified in the services provided. I further understand that unless specified otherwise below, this informed consent will continue in effect during my participation or within one year, whichever is less, within the program for which disclosure of the above-described date is made. I also understand by signing below I am consenting to all non-crossed out areas above.

I have read the Carver County Data Privacy Rights and the HIPAA Privacy Practices and I agree to let Carver County Health and Human Services collect, release, and exchange information with those listed above.

I acknowledge that I have received a copy of my rights, including my Appeal Rights per health plan requirements or Department of Human Services requirements.

If a specific expiration date other than the above, so state: _____

Signature of Client or Legal Representative **Date**