HCLC12010 (04/05/2019)

# AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION/RECORDS

## **HSPHD Contact Person**

Hennepin County Health and Human Services

All Fields/Sections marked with an asterisk (\*) are required.

* Full Name Human Services and Public Health - Homeless to Housing Program			* Phone Number *	
Client Informa	ation			
* Client Full Name		Phone Number		
SMI Number	Maiden, Previous Names or Aliases		* Date of Birth	
* Street Address		* City	* State	* ZIP Code
Email Address				

## \* Obtain/Release Statement

I authorize Hennepin County Human Services and Public Health Department				
O To obtain and release information / records on the above named client with:				
○ To release information / records on the above-named client to:				
○ To obtain information / records on the above-named client from:				
Contact Person / Organization				
Organization Person				
Organization Name				

Name	Phone Number		
Street Address Record(s) Requested	City	State MN	ZIP Code
<ul> <li>The record(s) will be used:</li> <li>To continue evaluation or treatment.</li> <li>To coordinate services.</li> <li>Other:</li> </ul>			



#### AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION/RECORDS

Admission/Intake Summary/Diagnostic Assessment	Mental Health				
Child and Family Identifying Info	Military Service and Veteran Status Records				
Chemical Dependency Assessment	MFIP/DWP M				
Chemical Dependency Program Information	OT, PT, Speech Assessments, and Progress Records				
Child Care Provider	Progress Reports, Treatment Records, ER Reports				
Child's Developmental History	Psychiatric Evaluation				
Community Corrections Record	Psychological Testing or Evaluation/Assessment				
Court Records	Psychotherapy Notes				
Discharge or Closing Summary	School Records, e.g. IEP, IFSP, Assessments, Transcripts				
Economic Benefits, e.g. Veteran's, Welfare, Social Security	School Verification				
Employment Verification	Service Plan (IPSP, IIIP, IEP, IHP, ILP, Wrap around Support Plan, etc)				
🗌 Financial Aid	Social History				
Financial Institution	Treatment Plan or Community Support Plan				
Immunization Records	US Citizenship and Immigration Services				
Interim Assistance	Vital Stats (birth, marriage, divorce and death)				
Laboratory Reports, e.g. Drug, blood	Vocational Reports				
Landlord/Property/Shelter verification					
Medical History and Data/Physical Exam/Medication Records	Veterans Services				
Other:					
Expiration					
$\bigcirc$ This authorization applies to an open HSPHD case and, unless specified below, is valid until case closure.					

- This authorization expires:
- If no event or date is specified, this authorization expires after 1 year.

#### **Client Authorization and Signature**

The information may be shared unless otherwise indicated, orally, in writing, or electronically.

- I have the right to refuse to sign this authorization. Treatment, payment or operations are not conditioned on my authorization.
- I may cancel this authorization at any time by contacting my worker if the release has not already been carried out. (Workers: use form HC12025 to document.)
- A copy of this authorization is as valid as the original.
- I may be required to pay the actual costs of making, certifying and/or compiling the copies of information requested.
- After this information is released, it may be re-released to a third party if allowed by law. However, 42 CFR Part 2 prohibits unauthorized re-release of substance use disorder records.
- If I have questions about the privacy of my records, I may ask my worker for more information.

If not signed by subject of disclosure, specify basis for authority to sign:

Parent of Minor

🗌 Guardian

Other personal representative

Printed Name of Person Signing

Client Signature

The information is available in other forms to people with disabilities. Call the county worker or contact the worker through the Minnesota Relay Service at **1-800-627-3529** - TTY

Date Signed