ANOKA COUNTY DIVISION OF HUMAN SERVICES
AUTHORIZATION TO RELEASE
CHEMICAL HEALTH OR MENTAL HEALTH INFORMATION

Use Separate Authorization for Each Entity

I, _____, _____, give my consent for Anoka County CSS&BH Dept. to release data about:
(Printed Full Name) (Date of Birth) (Agency/Unit)

Me and/or _____ _____ _____and
(Printed Full Name) (Relationship) (Date of Birth)

☐ I also agree the agency/person checked below can release data about the named individual to Anoka County.

☐ I also agree the agency/person checked below may have ongoing shared communication about the named individual with Anoka County.

To: Anoka County Social Services/Behavioral Health:

☐ LTSS ☐ Child Protection ☐ Adult Protection ☐ Disability & Aging Services
☐ Licensing ☐ Adult Mental Health ☐ Children's Mental Health ☐ Other:_____

☐ Anoka County Economic Assistance
☐ Anoka County Job Training Center
☐ Anoka County Corrections
☐ Anoka County Public Health Department
☐ Anoka County Veterans Services
☐ Anoka County Attorney's Office
☐ Mental Health Provider _____
☐ Medical /Dental Health Provider _____
☐ Chemical Health Assessor/ Treatment Center _____
☐ Other _____
☐ Other _____

The data authorized to be released consists of the following records, however **this authorization excludes "psychotherapy notes" as defined in 45 CFR 164.501.**

☐ Chemical Health Assessment/Consultation
☐ Service/ Treatment Plans
☐ Discharge Summary/ Aftercare Plan
☐ Psychiatric Evaluation/Assessment/Consultation
☐ Psychological Evaluation/Assessment/Consultation
☐ Psychological Progress Notes
☐ Residential Care Records
☐ Psychiatric progress notes
☐ Any Mental Health/Chemical Health data necessary to coordinate services, **including the re-release of records received from other agencies or medical facilities.**

Specific Description of mental and/or chemical health records to be released if needed:

_____

The records to be released are necessary for the purpose of determining eligibility for, planning and coordination of services and general program administration.

I understand that the Minnesota Government Data Practices Act and other laws require that this data remain private. This data cannot be released without my consent except as provided by law. I understand why I am being asked for this information. With my consent, this information could be shared with agencies and businesses that may not be covered by these laws. They could share this information with others. I was told of my right to refuse to release this data. I understand that if I refuse to release information the information will not be released unless the law otherwise allows its release. If I do not release information, services may not be available, or I may not receive all appropriate services. If I consent, this information will be used in arranging or providing services. A photocopy of this consent may be treated in the same manner as the original. I may cancel this consent by written request to Anoka County Human Services, Attn: Anoka County CSS&BH Dept., Anoka County Government Center, 2100 Third Avenue, Anoka, MN 55303.

Date: _____ _____ _____
Signature **Relationship to Client**

This institution is an equal opportunity provider