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

I, _____, _____, give my consent for _____ 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 agencies/persons checked below can release data about the named individuals to Anoka County.

☑ I also agree the agencies/persons checked below may have ongoing shared communication about the named individuals with Anoka County.

To:

- ☑ Minnesota Department of Human Services
- ☑ Anoka County WIC
- ☑ CMS – Center for Medicaid/Medicare Service U.S. Department of Health and Human Services
- ☐ Home Care Agency _____
- ☑ Anoka County Economic Assistance Department
- ☐ Hospital _____
- ☐ Medical Providers _____
- ☐ Therapist _____
- ☐ ARMHS _____
- ☐ Health Insurance _____
- ☐ CD Treatment Center _____
- ☐ (Other agency or person) _____
- ☐ Law Enforcement Agencies _____
- ☐ Anoka County Public Health Nursing
- ☐ Anoka Co. Community Health/Environmental Services
- ☐ School _____
- ☑ Anoka County Comm. Social Services & Mental Health
- ☐ Anoka County Child Protection
- ☐ Minnesota Department of Corrections
- ☐ Psychiatrist _____
- ☐ Psychologist _____
- ☐ Contracted Interpreter Agency _____
- ☐ ILS _____
- ☐ Pharmacy _____
- ☐ (Other agency or person) _____

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

- ☐ Hospital Records/Medical Treatment
- ☐ Chemical Health Assessment/Consultation
- ☐ Service/ Treatment Plans
- ☐ Discharge Summary/ Aftercare Plan
- ☐ Psychiatric Evaluation/Assessment/Consultation
- ☐ Psychiatric progress notes
- ☐ Any Mental Health/Chemical Health data necessary to coordinate services
- ☐ School Records
- ☐ Police/Case Records
- ☐ Court Records/Reports
- ☐ Residential Care Records
- ☐ Psychological Evaluation/Assessment/Consultation
- ☐ Psychological Progress Notes
- ☐ Other _____

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. My consent will expire one year from the date of my signature. 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 Community Social Services and Behavioral Health Department, Anoka County Government Center, 2100 Third Avenue Suite 340, Anoka, MN 55303.

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

This institution is an equal opportunity provider