ANOKA COUNTY DIVISION OF HUMAN SERVICES
AUTHORIZATION TO RELEASE INFORMATION

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 agencies/persons checked below can release data about the named individual to Anoka County.

☐ I also agree the agencies/persons 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 Public Health Nursing/WIC (PHN)
☐ Anoka County Corrections
☐ Minnesota Department of Human Services (DHS)
☐ The Minnesota Immunization Information Connection
☐ Contracted Interpreter Agency _____
☐ School _____
☐ Early Childhood Family Education (ECFE)
☐ Hospital _____
☐ Hospital _____
☐ Medical/Dental Provider _____
☐ Medical/Dental Provider _____
☐ Health Insurance _____
☐ Pharmacy _____
☐ Family/Friend _____
☐ Other _____

☐ Anoka County Economic Assistance
☐ Anoka County Job Training Center
☐ Minnesota Department of Health (MDH)
☐ Center for Medicaid/Medicare Service – US Department of Health and Human Services (CMS)
☐ Anoka County Community Action Program (ACCAP)
☐ Home Care Agency _____
☐ Home Delivered Meals _____
☐ Transportation Services _____
☐ Anoka County Attorney's Office _____
☐ Service Provider _____
☐ Service Provider _____
☐ Service Provider _____
☐ MN County _____
☐ Other _____

The data authorized to be released consists of:

☐ Service/Treatment Plans
☐ School Records/Academic Progress/Test Results
☐ Hospital Records/Medical Treatment
☐ Discharge Summary/Aftercare Plan
☐ Health Records
☐ Client Records

☐ Employment Verification
☐ Financial/Accounting Records
☐ Claims payment
☐ Police/Case Records
☐ Court Records/Reports
☐ Other _____

☐ **This Authorization permits the re-release of records received from other agencies or medical facilities.**

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**

Authorizations and requests for Mental Health or Chemical Dependency Records may not be combined on the same form with other requests for information. See Anoka County - Division of Human Services Authorization to Release Chemical Dependency or Mental Health Information.

This institution is an equal opportunity provider