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 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
- ☑ CMS – Center for Medicaid/Medicare Service U.S. Department of Health and Human Services
- ☐ School _____
- ☑ Anoka County Community Action Program (ACCAP)
- ☑ Anoka County Economic Assistance Department
- ☐ Anoka County Job Training Center
- ☐ Hospital _____
- ☐ Medical Providers _____
- _____
- ☐ Health Insurance _____
- ☐ Long-Term Care Facility _____
- ☐ Pharmacy _____
- ☐ Adult Day Services _____
- ☐ Family/Friend _____
- ☐ Family/Friend _____
- ☐ Supplies/Equipment _____
- _____
- ☑ Anoka Co. Community Health/Environmental Services
- ☑ Anoka County Public Health Nursing
- ☐ Anoka County WIC
- ☐ Anoka County Child Protection
- ☑ Anoka County Community Social Services & Mental Health Department
- ☐ ILS _____
- ☐ Home Care Agency _____
- ☐ Early Childhood Family Education (ECFE)
- ☐ Contracted Interpreter Agency _____
- ☑ The MN Immunization Information Connection (MIIC)
- ☐ Housing Provider _____
- ☐ Transportation Services _____
- ☐ Home Delivered Meals _____
- ☑ Minnesota Department of Health
- ☐ Lifeline _____
- ☐ Other _____
- ☐ Other _____

The data authorized to be released consists of:

- ☐ Claims payment
- ☐ School Records/Academic Progress/Test Results
- ☐ Police/Case Records
- ☐ Service/Treatment Plans
- ☐ Employment Verification
- ☐ Health Records
- ☐ Hospital Records/Medical Treatment
- ☐ Financial/Accounting Records
- ☐ Court Records/Reports
- ☐ Discharge Summary/Aftercare Plan
- ☐ Client Records
- ☐ Other _____

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 CSS/BH Dept., Anoka County Government Center, 2100 Third Avenue Suite 340, 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