AUTHORIZATION FOR THE RELEASE OF INFORMATION

PUBLIC HEALTH DEPARTMENT: (507) 328-7500 ~ ***COMMUNITY SERVICES DEPARTMENT: (507) 328-6400***
2100 Campus Drive SE, Suite 100 ▪ Rochester, MN 55904 ***2100 Campus Drive SE, Suite 200 ▪ Rochester, MN 55904***

CLIENT:	Name: Address:	Date of Birth: Phone:	Social Security Number:

I give Olmsted County permission to share information about myself with and receive information from:

MUTUAL RELEASE AND SHARING OF PRIVATE INFORMATION: ***(check all entities or persons your information can be sent to or received from)***		
	☐ Mayo Clinic & All Affiliates	☐ Home Care Provider (specify):
	☐ Olmsted Medical Center & Satellites	☐ Pharmacy (specify):
	☐ School (specify):	☐ Dentist (specify):
	☐ Family Members (specify):	☐ Legal Counsel (specify):
	☐ Between Olmsted County Departments: (except Public Health Department) (i.e. Probation and Adult Services) Probation and Adult Services	
	☒ Other (Please specify facility and address below, including phone/fax if known): Facility initiating chemical dependency treatment and facility completing Rule 25 assessment	

RECORDS DATE RANGE:	☐ Date range not limited ☐ Limited to this date range From: _____/_____/_____ To: _____/_____/_____	
INFORMATION TO BE DISCLOSED:	☐ Medical History Summary	☐ Child Protection Assessment Summary
	☐ Psychiatric Assessment	☐ Case Notes / Progress Notes
	☐ Diagnostic Assessment	☐ Billing Statements / Financial Data
	☐ Psychological Testing	☐ IEP/School Assessment
	☒ Other (specify): Rule 25 assessment information/CD treatment and progress	

PURPOSE OF RELEASE:	☒ Treatment/Continued Care	☐ Attorney/Legal	☐ Disability Determination
	☐ Research/Statistical Data	☐ Insurance Claim/Application	☐ Investigation (specify):
	☐ Requested by Client or Guardian	☐ Other (specify):	

This authorization is voluntary. I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I understand Olmsted County and the other parties named above may not condition my receiving services upon my providing this authorization unless the information is necessary for determining my eligibility for services or for providing services. I understand that if I refuse to sign this authorization Olmsted County and the other party named above may not be able to provide some or all of the services I may need or request. I understand that the individual(s) or entities to which my information is being disclosed may not be subject to state or federal privacy laws. My information may not be protected by law if the entity that receives it is either required or permitted to disclose it to someone else. I understand that I may revoke this authorization at any time by giving written notice of revocation to Olmsted County or the other parties named above. I understand that revocation of this authorization will *not* affect any action taken by Olmsted County or the other parties named above in reliance upon the authorization prior to receiving my written notice of revocation. I have received a copy of this statement, which I can retain. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

_____ **Client Initials** **I have received the Notice of Privacy Practices and have been informed of my rights.**

_____ **Client Initials** **I have received the Appeal Rights Notice and have been informed of my rights.**

➢ _____ _____

Signature of individual authorizing release (if client is 18 years of age or older) **Date**

➢ _____ _____

Signature of parent or guardian (if client is 17 years of age or younger unless exception exists under state or federal law) **Date**

Signature of authorized representative (if client is 18 years of age or older and incapable of signing, then indicate your legal authority and include documentation of your relationship)

➢ _____ _____

Signature of interpreter (if required) **Date**