Le Sueur COUNTY

Department of Human Services

88 SOUTH PARK AVENUE • LE CENTER, MINNESOTA 56057-1646
507-357-8288 • FAX 507-357-4220

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____

(Name of individual releasing information)

Address	Birth Date	Social Security Number
City	State	Zip

(Identifying information about person releasing information)

Authorize _____ to

(Name of individual or entity maintaining data about me or my legal dependent)

☐ exchange ☐ disclose

the following information about me to Le Sueur County Human Services.

(Name of individual(s) or entities receiving the information)

Information to be released:

- ☐ Discharge or closing summary
- ☐ Laboratory reports: _____
- ☐ Medical history/physical exam
- ☐ Social service records
- ☐ Progress Reports
- ☐ Treatment records
- ☐ Emergency room reports
- ☐ Admission/intake summary/diagnostic assessment
- ☐ Psychiatric evaluation
- ☐ Social history
- ☐ Psychological testing or evaluation
- ☐ Treatment plan or community support plan
- ☐ Birth records
- ☐ School records, IEP assessments, transcripts
- ☐ Vocational reports
- ☐ Medication records
- ☐ Immunization records
- ☐ Court records
- ☐ Chemical dependency evaluation
- ☐ Other: _____

☐ **Yes** ☐ **No** **I am agreeing to the release of drug and alcohol treatment records.**

The information is needed to:

- ☐ Continue evaluation or treatment
- ☐ Coordinate services
- ☐ Determine eligibility for case management services
- ☐ Other: _____

State and Federal privacy laws protect my records. By signing this, I attest to understanding:

- Why I am being asked for this information.
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be exchanged/disclosed unless otherwise permitted by law.
- I may end this authorization with written notice at any time, but this written notice will not affect information the agency has already exchanged/disclosed.

This authorization ends _____, or one year from the date I sign it, unless the law allows for a longer period.

(Date)

SIGNATURE OF INDIVIDUAL AUTHORIZING RELEASE	DATE
SIGNATURE OF WITNESS (if required)	DATE
SIGNATURE AND RELATIONSHIP OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE (if required)	DATE