Southern Minnesota BEHAVIORAL HEALTH

CONSENT FOR THE RELEASE OF INFORMATION

Client Name: _____ [Previous Name(s) _____] Birth Date: _____

I am requesting that my health information be: ☐ **Verbal and Written** ☐ **Verbal** ☐ **Written**

Name: _____ Relationship to client: _____

Facility name _____

Facility Phone _____ Facility Fax _____

Please check information to be released and indicate the dates of service to be included: From: _____ **To:** _____

Purpose: Coordination of Care

- ☐ Discharge Summary
- ☐ Evaluations/Assessments including Diagnostic, Psychiatric, Psychological, Medical, Chemical Dependency, Emergency
- ☐ Psychotherapy Notes
- ☐ Treatment Plan/Rehabilitation Plan/Community Support Plan
- ☐ Laboratory reports
- ☐ Court/Corrections Information
- ☐ School or Educational Information (may include academic progress; behavioral issues; Special Education data)
- ☐ Social Services Agency Information
- ☐ Other (specify): _____

I UNDERSTAND THAT:

- I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information, and any known consequences of this release. The information to be released is private and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn.Stat.1982 Chap.13)
- I understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. Further, I realize Southern Minnesota Behavioral Health cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections: therefore, Southern Minnesota Behavioral Health is released from any and all liability resulting from re-disclosure.
- I have the right to revoke this authorization at any time by giving written notice to SMNBH. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire within one (1) year after the date of my signature. I understand that the revocation will not apply: 1) To information that has already been released in response to this authorization; or 2) to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
- I need not sign this authorization to receive services unless the services are court-ordered or are being created solely for a third party (i.e., consultation).
- This authorization will permit two-way telephone communication and exchange of information by electronic methods.
- I am entitled to a copy of this authorization once I have signed it, and I may review/request copies of information disclosed. A photograph or facsimile of this authorization is as effective as the original.
- I have been informed of my right to refuse to release this information.

Date, event, or condition upon which this consent expires: Click or tap to enter a date. **(one year maximum)**

_____ _____ _____

Client/Parent/Guardian Signature | Date | Relationship to Client if Client isn't signing

Information released to Southern Minnesota Behavioral Health should be sent to:

1407 S State St., New Ulm, MN 56073 Phone 507-354-3181 Fax 507-388-3199