RAMSEY COUNTY

Authorization/Consent for Release of information

1.) Client Information:

First Name	Middle Initial	Last Name	
Date of Birth	Social Security Number *(optional)*	Gender *	Client ID/Case No.
Street Address			
City	State *	Zip	
Phone No.	Phone No.	Phone No.	

2.) I authorize/consent that my information be released from:

Organization Name *
Address/Phone
Other - *Specify*

3.) I authorize/consent that my information be sent to:

☐ On-Site Review of Record	or	Organization Name *
Other - *Specify*		
First Name	Last Name	Phone No.
Street Address		Fax No.
City	State *	Zip

4.) Information Exchange:

By initialing here, I authorize/consent the two organizations named above to exchange written and verbal information regarding the client listed above: _____.

5.) Purpose for releasing information:

Purpose *
Other - *Specify*

6.) I am requesting you to release the following information:

Specific Dates/Years of Treatment/Service	From Date	To Date

RAMSEY COUNTY

EXTERNAL AUTHORIZATION/CONSENT FOR THE RELEASE OF INFORMATION

First Name	Last Name

All Health Information ***(you must enter your initials)***:_____

Disclosure of the following requires special consent by law. Even if you indicate "all health information", above, you must specifically authorize/consent to the disclosure of psychotherapy notes. **Initial here if you authorize/consent to disclosure of Psychotherapy Notes:** ____

OR

Describe the information you wish to be disclosed. ***Note: The description must be specific and meaningful and include explicit description of any substance use disorder information to be disclosed; the disclosure must also be limited to that necessary to carry out the stated purpose of this consent.***

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I understand that this information about me is protected under state and/or federal privacy laws and cannot be disclosed without my written authorization unless otherwise provided for by state or federal law. I understand that I may submit a written request to revoke this consent at any time. (Send to: Ramsey County Mental Health Center, Attn: Medical Records, 1919 University Ave. W., Ste. 200, St. Paul, MN 55104.) I understand that revoking this authorization/consent does not apply to information that has already been released in reliance on this authorization/consent.

Ramsey County may condition certain services, except treatment, payment for treatment or enrollment or eligibility for services, on whether or not I sign this authorization. If I do not sign this form, such services may or may not be provided to me, based on program requirements. I understand that if the organization named in section 3 (the party or entity I am requesting that my information be sent to) is a health care provider they will not condition treatment, payment or enrollment or eligibility for benefits on whether I sign this form.

Notice of Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any other disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or though verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see Section 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance abuse disorder, except as provided at Sections 2.12(c)(5) and 2.65.

A photocopy of this Authorization/Consent shall be treated in the same manner as the original.

7.) Expiration Date / Signatures: *I understand that this consent will expire one year from the date I have signed it or upon fulfillment of the purpose stated in Section 5, above, whichever event occurs earlier:*

The consequence of giving informed consent must be shared before signing. If you have questions about the information on this form, ask your therapist, nurse, doctor or worker.

	Date of Expiration:		
	Client Signature	Date	
	Signature of Parent, Guardian, Rep (if required)	Date	
	Relationship to Client (if required)	Date	
	Signature of Witness (if required)	Date	