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|  | **Release of Information Consent Form for Team C** |  |
|  | **Dakota County Community Living Services (CLS)****1 Mendota Road W., Suite 300, West St. Paul, MN 55118****Phone: 651-554-6000 Fax: 651-554-6043** |  |

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| I,  |       | D.O.B. |       |

give my consent to Dakota County CLS to [x]  exchange information with:

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| [x]  | Dr. Reiko Tanaka PSY.D., LP at Associated Clinic of Psychology when updated testing is needed | [x]  | Other providers with evaluation/test results:      |
| [x]  | School District#       | [x]  | Primary Doctor:      |
| [x]  | Public Health Nursing | [x]  | If over age 18 without guardianship established; parent(s): |
| [x]  | E&EA (MA/TEFRA worker) | [x]  | FSE (if on a self-directed program):      |

\*Please note that you may cross out any of the above listed providers if you do not wish to exchange information

The following information:

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| [x]  Academic Records/IEP | [x]  Psychological Evaluations | [x]  Diagnostic Information |
| [x]  School and/or Provider Evaluations | [x]  Medical Records | [x]  Mental Health |

for evaluation, treatment, payment, healthcare operations and delivery of services in accordance with services to be provided.

**The purpose of this disclosure is to review and evaluate continued eligibility for DD case management and/or my need for services and to refer to appropriate resources.**

If I receive CSG, FSG or CDCS I also give my consent to Dakota County CLS to exchange information with the following in order to administer my program:

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| [x]  Fiscal Support Entity:       | [x]  PCA Assessor: (if not PHN) for CSG program (if used)       | [x]  Support Planner:       |

**\*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\* \*\***

I understand that my records are protected under the Minnesota Government Data Privacy Act (Minnesota Statute Chapter 13), the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162, and 164), and other applicable state and federal privacy laws. I understand that this information cannot be released without my consent and that I am under NO OBLIGATION to release it. I understand that I may release all, some, or none of the information. I understand that I have a right to see the information and have a copy of it. I understand that I may revoke this Consent at any time by express written notice to either address noted above, except to the extent that action has already been taken in reliance on it or information has already been received as a result of it. Unless I revoke my consent sooner, my permission to allow the release of this information will automatically expire one (1) year from the date I sign this release. I understand that if there is a child protection hearing, the information collected from me will become public if submitted in a report to the court or if introduced at court pursuant to Minnesota Rules 44.01 and 44.02 of the Rules of Juvenile Procedure, except for the data specifically listed in Rules 8.01 through 8.08 of the Minnesota Rules of Juvenile Procedure. I understand that in accordance with 45 CFR Part 164.508, subd. c (2) (iii), you are informing me that the individual(s) or entities whom you are authorized to disclose your information to may not be subject to the same privacy rules as Dakota County and there may be the potential of redisclosure of the private information. I understand that my eligibility to receive benefits from Dakota County Community Living Services will not be affected if I refuse to sign this release. However, I also understand that if I refuse to sign this Consent, it could affect the County’s ability to determine what services I need or am qualified to receive.

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|  |  |  |  |  |
| Date |  | Signature of Client/Parent/Guardian |  | Relationship to Minor Client |

**Notice to Recipients of Information:** If you have received information related to drug or alcohol abuse by the client, you must include the following statement when further disclosing information as required by 42 CFR Part 2.32. “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 further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”