DAKOTA COUNTY COMMUNITY SERVICES

DAKOTA COUNTY SOCIAL SERVICES
ADULT SERVICES
1 MENDOTA ROAD WEST, STE 300
WEST ST. PAUL MN 55118-4770

RELEASE OF INFORMATION CONSENT FORM

CHEMICAL HEALTH SERVICES

(FORM IS NOT VALID UNLESS COMPLETED IN FULL)

I, ________________________, Birthdate _____________________, authorize Dakota County Social Services to:

- ☐ Exchange with the following individual(s) or entity(ies): ____
- ☐ Obtain from the following individual(s) or entity(ies): ____
- ☐ Release to with the following individual(s) or entity(ies): ____

The following information:

☐ School Achievement & Behavior Report	☒ Bio/Psycho/Social	☒ Progress Note/Treatment Plan Reviews
☒ Psychological Evaluation	☒ Substance Use Disorder Assessment	☒ Summary of Social History
☒ Discharge/Treatment Summary	☒ Treatment Recommendations/Referral	☐ Other _____

The purpose for disclosure is: Referral and coordination of care at a Chemical Health Treatment Facility.

This consent expires automatically twelve (12) months from the date this consent is signed, unless earlier revoked by me.

I understand that my records are protected under the Minnesota Government Data Privacy Act (Minn. Stat. 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 written consent, unless otherwise authorized by law, 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 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 I have a right to see the information and have a copy of it. I may revoke this Consent at any time in writing, however, revocation will not pertain to data released or obtained prior to the County's receipt of the written revocation notice at one of the addresses noted above. 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 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 my 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 Social 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.

Date: ________________________________

Person Requesting Release: ____

Client Signature: ____

Parent/Guardian:
(if client under 18 or under legal guardianship) ____

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."