Two-Way Authorization for the Release of Information

I, _____ **authorize**

(name of individual authorizing release and, if required, address, client number, social security number, etc. to identify this individual from other similar names in agencies' files)

_____

_____

(name of individual or entity maintaining data about me or dependent family members)

to disclose "to" and "receive" from Otter Tail County Human Services private data about me via:

☐ **FAX** ☐ **Face to Face** ☐ **Telephone** ☐ **E-mail** ☐ **Written**

the following information:

☐ Discharge or Closing Summary
☐ Laboratory Reports – List:_____
☐ 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
☐ Immunization Records
☐ Vocational Reports
☐ Medication Records
☐ Court Records
☐ Chemical Dependency Evaluation
☐ Other:_____

for the purpose of:

☐ To continue evaluation or treatment
☐ To coordinate services
☐ To determine eligibility for case management services
☐ Other:_____

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. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent with written notice at any time, but that 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.

I understand that if the person or organization I authorize to receive the information is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.

This consent ends _____ or one year from the date I sign it, or other periods as provided by law.

(*A photocopy/fax is valid as original signature*)

_____ _____
Signature of individual authorizing release Date

_____ _____
Signature of witness (if required) Date

_____ _____
Signature and relationship of parent, guardian or authorized representative (if required) Date

NOTE TO AGENCIES USING THIS FORM: The consequences or giving informed consent must be communicated to the individual prior to signing his/her signature. The individual who consents to release personal information must be provided a signed (executed) copy of the authorization.