



Release Form #2
(For Internal Partners Only)

Consent for the Release of Information

I, _____ (DOB __/__/__), understand that by signing this consent form I am authorizing Washington County Community Services to share and discuss written, electronic and verbal information checked off below about me that they determine is appropriate. Information about me will be released and exchanged with the agencies that I have indicated below.

- Washington County Adult Mental Health Unit (including State, HSI and County staff)
Washington County Adult Services Unit
Washington County Chemical Health Unit
Washington County Children's Services Unit
Washington County Community Corrections
Washington County Developmental Disabilities Unit
Washington County Economic Assistance
Washington County Public Health & Environment
Washington County Resource Unit
Washington County Sheriff's Office
Human Services, Inc. (HSI)
Veterans Services
Workforce Center

Dates of service (if applicable) _____

Information to be released and exchanged:

- Admission and Discharge Summaries
Assessment/Screening Reports
Social Services Agency Records
Medical Records
School Reports
Social History
Court / Court Services Records
Treatment Plan and Progress Summaries
Other Records

- Mental Health Records
All Mental Health Records
Only Mental Health Records as follows: _____

- Chemical Health Records
Reason(s) for releasing chemical health information:
Patient's request
Payment
Review patient's current care
Insurance application
Treatment / Continued care
Legal
Other

Chemical Health information is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit any further disclosure of this 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 or the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that by signing this form I am requesting that the information specified above be released and exchanged between the agencies listed above. This information is being released and exchanged for the purpose of determining eligibility, identifying appropriate services, planning treatment, coordinating services, and reviewing the need for continuation and/or change in services. I understand that my records are protected under state and/or federal privacy laws and cannot be disclosed without my written consent unless otherwise provided for by state or federal law.

I may stop this consent at any time by writing to the organizations, facilities, and/or individuals listed above. If the organizations, facilities and/or individuals listed above have already released and exchanged information based on my consent, my request to stop this consent will not work for that information.

I understand that when health information is released and exchanged between the parties listed above, the information could be redisclosed by a third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the agencies listed above are health care providers, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This release expires in one year unless otherwise indicated by date or condition: _____

Client Signature _____ Date _____

Signature of parent, guardian, or authorized representative when required _____ Date _____

- Service Center Cottage Grove
Service Center Forest Lake
Government Center
Service Center Woodbury