CHISAGO COUNTY HEALTH, HUMAN & SERVICES

313 North Main Street, Room 239
Center City, MN 55012-9665

General Information	651-213-5600
Administration	651-213-5609
Child Support	651-213-5647
Financial Assistance	651-213-5640
North Branch	651-213-5200
Center City	651-213-5600
Welfare Fraud	651-213-8808
Fax-Center City	651-213-5685
Fax-North Branch	651-213-8955
Public Health	651-213-5231
Veterans office	651-213-5605

WORKER: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Client: _____
Date of Birth: _____Phone #: _____
I authorize the disclosure and/or exchange of information **between**:

_____
_____
_____
_____

AND

Chisago County Health and Human Services
6133 402nd Street
North Branch, MN 55056
651-213-5200

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(**Specify** dates for each, unless "entire record" is to be selected)

_____ Hospital treatment from _____ to _____
_____ Hospital Admission/Discharge Summary
_____ School Records
_____ Therapy/Counselor records
_____ Social Service Records
_____ Chemical Health Records
_____ Medical Clinic Records
_____ Title IV-E Candidacy Status
_____ **Other** (please specify) _____
_____ Psychiatric Intake
_____ Psychiatric Summary
_____ MFIP Records
_____ Public Health Records
_____ CD Treatment records
_____ Probation/Correction Records
_____ Domestic Violence Records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
_____ **Do not** release records from alcohol or drug abuse treatment programs that are protected under federal law.

The purpose of the use and disclosure is: Coordination of home and community based services.

I authorize the use and disclosure of my individually identified information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed.
I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire **on** _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original. This exchange of information may be in either written or verbal form.

_____ _____
Signature of Client/Guardian/Representative Date

_____
(If not client, state authority/relationship)

Chisago County is An Equal Opportunity Employer