APPENDIX II

FORM 2

AUTHORIZATION TO RELEASE INFORMATION

DEPARTMENT OF HUMAN SERVICES

DHS-2243A-ENG

CHILDREN AND FAMILY SERVICES - ECONOMIC ASSISTANCE AND EMPLOYMENT SUPPORTS

General Authorization for Release of Information

***IMPORTANT:** If you are not able to complete this form online, click Print Blank Form to print the form and complete it by hand.

Print Blank Form

Date: [date]

Case number: [case number]

Worker name: [first name] [last name] Worker phone: [phone number] Worker fax: [fax number]

Agency name: [agency name]

Agency address:

[street address]

To: [name]

[street address]

[city], [state] [zip code]

We need to verify information for the person(s) listed below:

PERSON'S NAME	SOCIAL SECURITY NUMBER

Add name

Please provide the information requested. **Attach verification documents *or* record the information on the back of this form and sign where indicated.** Return the form to the requesting agency. On the bottom half of this form is a signed authorization to release information to the human services agency listed above.

Thank you for your cooperation.

Authorization for release of information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent

- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by DHS, it may no longer be protected by this

authorization. This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE	DATE	Original copy for agency Provide copy to client
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	

CASE NUMBER: _____

To be completed by verifying agent

(Mail or fax to agency address/fax number on first page)

VERIFYING AGENT'S	
PHONE NUMBER	DATE

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါဖံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီဒးပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your countv's ADA coordinator. ADA4 (2-18)

Authorization for Chemical Dependency Program Services

☑ Show DHS Form Version

AUTHORIZATION FOR RELEASE OF INFORMATION

Clay County Social Services - Chemical Dependency Unit 715 North 11th Street, Suite 502, Moorhead MN 56560

1 CLIENT	**FULL LEGAL NAME:**_____ **DOB:**_____ **PREVIOUS NAME:** _____
2 RELEASE INFORMATION FROM (who has the information you would like released)	☐ **Clay County Social Services, Behavioral Health Services, 715 N 11th ST, STE 502, Moorhead, MN 56560** ☐
3 RELEASE/DISCLOSE INFORMATION TO (send information to)	☐ **Clay County Social Services, Behavioral Health Services, 715 N 11th ST, STE 502, Moorhead, MN 56560** ☐
4 INFORMATION TO BE OBTAINED OR DISCLOSED ABOUT THE CLIENT NAMED ABOVE IN BOX 1 (only the information check marked will be released	**Dates of Service: From**_____**to**_____***Information from the past 12 months will be released unless dates are specified.** ☐ **Admission Summary** ☐ **Comprehensive Assessment** ☐ **Recommendations** ☐ **Discharge Summary** ☐ **DOC/Probation Records** ☐ **Diagnostic Assessment** ☐ **Progress Notes/Reports** ☐ **Court Records** ☐ **CD Tx Plans** ☐ **Lab Reports** ☐ **Dept. of Public Safety Records -MN** ☐ **Mental Health Tx Plans** ☐ **Contact Notes** ☐ **Dept. of Transportation Records- ND** ☐ **Social History/Physical** ☐ **Collateral Info from:**_____**(Name of Person)** ☐ **Other:**
5 SPECIAL DISCLOSURES	☐ **Alcohol and/or Drug Abuse/ Records** ☐ **Psychiatric and/or Mental Health** ☐ **HIV** ☐ **From**_____**to**_____**concerning**_____**(specific diagnosis or tx)** ☐ **Verbal discussion only—Do Not Release written records**
6 REASON FOR DISCLOSURE	**Release of private data and/or consent to contact collateral source for:** **Service Coordination** ☐ **Comprehensive Assessment** ☐ **Monitoring for Court** ☐ **Disability Determination** ☐ **Referrals for Treatment Placement** ☐ **Determine eligibility for services** ☐ **Other: Case management**
7 REVOCATION	**This authorization is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon** _____**(date) 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 an original.** **Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which:** **(1) Has expired;** **(2) On its face substantially fails to conform to any of the required elements in CFR42;** **(3) Is known to have been revoked; or** **(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.**

8 **AUTHORIZATION**	**I give permission for the person/organization above to release the requested information to the above agency. I know:** • **Why I am being asked to release this information, who will receive this information and any known consequences of this release** • **That my records can be released only if I give written permission or if the law allows it** • **That if I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting** • **That the information to be released is private and any subsequent use and release is controlled under the Minnesota Government Data Practices Act and Code of Federal Regulations(CFR) 42, parts 2.31** **_____ _____** **Client Signature** **Date** **_____ _____** **Signature of Person Authorized to Consent in Lieu of Person (where required)** **Date** **☐ Parent of Minor ☐Guardian ☐Other personal representation(explain)**

Authorization for Disability Services, Long-Term Services and Support, and CHILDREN AND FAMILY SERVICES

Minnesota Department of **Human Services**

DHS-3377-ENG 9-11

Social Services Authorization for Release of Information

I, _____ authorize
(Name of individual authorizing release*)

_____

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

to disclose private data about me to _____.
(Name of individual(s), or entities to receive the information)

*Provide the following information if required to identify this individual from other similar names in agencies' files:				
ADDRESS				CLIENT NUMBER
CITY		STATE	ZIP CODE	SOCIAL SECURITY NUMBER
BIRTH DATE	OTHER IDENTIFYING INFORMATION			

Provide 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:

The information is required to:

- ☐ Continue evaluation or treatment
- ☐ Coordinate services
- ☐ Determine eligibility for case management services
- ☐ Other:

_____

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked for this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be shared/released unless the law otherwise allows it
- I may stop this authorization with written notice at any time, but that this written notice will not affect information the agency has already shared/requested.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

Social Services Authorization for Release of Information

This authorization ends _____, or one year from the date I sign it, unless the law allows for a longer period.
(date)

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: Prior to having this form signed you must communicate the consequences of giving informed consent to the individual. Provide a signed (executed) copy of the authorization to the individual who consents to release personal information.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

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Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါဆံၤနှဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီဒးဘပှၤမၤစၢၤတ်လၢနကိ်ာ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

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Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LBI (8-16)

ADA5 (5-09)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.