Consent to Release and Exchange Personal Information Between Your Care Team Agencies

Purpose of the exchange of information: Coordination of your care
This release will permit the individuals and agencies involved in your care, to work together in a confidential, professional manner to meet your needs.

Patient Name: _____ Date of Birth: _____
Full Address: _____
Phone Number: _____
Maiden/ Previous Name: _____
PCP:_____ Primary Clinic:_____

Type(s) of information to be exchanged, verbally & written, if necessary to coordinate your care and improve your wellness:

- History and Physical
- Diagnoses
- Medications
- Progress Notes
- HIV/ Aids testing
- Care Plan or Treatment Plan
- School IEP & Assessments
- Immunizations
- Emergency and Urgent Care Reports
- Discharge/ Treatment Summary
- Mental and Chemical Health Diagnoses, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications

Identify which of the following agencies and/or individuals are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above Cross out *and* initial any agency you *do not* give permission to share information with.

- Southwest Mental Health
- Southwest Health and Human Services
- Sanford Health
- Rock County Food Shelf
- _____ School District
- Luverne Head Start
- Good Samaritan Society (Mary Jane Brown Home, Popular Creek, The Oaks)
- Minnesota Veterans Home
- Minnesota West- Luverne Campus
- Rock County Law Enforcement
- Southwest Minnesota Crisis Center
- Rock County Crisis Response Team
- Avera Behavioral Health
- Avera Marshall Behavioral Health
- Other:

I AUTHORIZE RELEASE OF ALL ALCHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS ~~I~~SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

____Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance and this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. If you allow the release and exchange of information, this consent will expire in one year and/or you may cancel this consent at any time in writing to any agency to which you authorized us to share information on your original, signed consent form.

Signature (required):	**Date Signed** (required):
Printed Name of person signing (if not patient):	