

Polk-Norman-Mahnomen Community Health Services

Polk County Public Health (PCPH), 816 Marin Ave. Ste#125, PO Box 403, Crookston, MN 56716

Norman-Mahnomen Public Health (NMPH), 16 E 3rd Ave. Rm 107, Ada, MN 56510 / 115 Madison Ave., PO Box 226, Mahanomen, MN 56557

Consent to Release and Exchange Personal Information between Your Health Care Team Agencies

Reason for releasing information: Coordination of your care. This release will permit individuals and agencies you choose to release and exchange information to work together in a manner to meet your wellness and health needs while protecting your privacy.

Personal Information:

Last Name	First Name	Middle Name
Date of Birth	Street Address, City, State, Zip code	
Phone Number	Email Address (optional)	Medical Record/Patient ID Number (optional)

Type of information to be released and exchanged as it pertains to helping the team to assist in your care:

<input type="checkbox"/>	Specific dates/years of treatment:		
<input type="checkbox"/>	All health information*		
<i>OR to only release specific portions of your health information, indicate the categories to be released:</i>			
<input type="checkbox"/>	Assessments, Treatment or Care Plan	<input type="checkbox"/>	School Interagency Education Plan & Assessments
<input type="checkbox"/>	Diagnosis and Diagnostic Tests	<input type="checkbox"/>	Immunizations
<input type="checkbox"/>	Medications	<input type="checkbox"/>	HIV/AIDS Testing
<input type="checkbox"/>	History and Physical	<input type="checkbox"/>	Emergency/Urgent Care Reports
<input type="checkbox"/>	Progress Notes	<input type="checkbox"/>	Discharge/Treatment Summaries
<input type="checkbox"/>	Mental Health: Diagnosis, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications		

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:*

<input type="checkbox"/>	Chemical Health: Diagnosis, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications
<input type="checkbox"/>	Psychotherapy notes

• Check the item or items in the table above that you **give permission to be released and exchanged.**
 • Initial here if you **do not give permission to release and exchange any of this information:** _____

Specify Agencies and Providers that may release and exchange information which are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above:

<input type="checkbox"/>	Polk County Public Health/Norman-Mahnomen Public Health/WIC	<input type="checkbox"/>	Nurse Family Partnership National Service Office (NFP NSO)
<input type="checkbox"/>	Human/Social Services:	<input type="checkbox"/>	Community Action Agency: Tri-Valley Opportunity Council, Inc.
<input type="checkbox"/>	Hospitals:	<input type="checkbox"/>	Special Education:
<input type="checkbox"/>	Clinics:	<input type="checkbox"/>	Community Action Agency: MAHUBE-OTWA
<input type="checkbox"/>	Pharmacies:	<input type="checkbox"/>	Clay County Public Health
<input type="checkbox"/>	Mental Health Clinics/Providers:	<input type="checkbox"/>	Minnesota Department of Health(MDH)-FHV Unit **
<input type="checkbox"/>	School Districts	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Family Members (specify)		
<input type="checkbox"/>	Minnesota Department of Health (MDH)		
<input type="checkbox"/>	North Dakota Department of Health (NDoH):		
<input type="checkbox"/>	Other:		

• Check the agency or agencies in the table above that you **give permission to release and exchange your information.**
 • Initial here if you **do not give permission for any of these agencies to release and exchange your information.** _____
 **MDH Family Home Visiting (FHV) Reporting System requests information regarding the entire time enrolled in a FHV program. Information will be shared with and stored by MDH. MDH and its contractors (including MN FHV providers) will use the information for administering and evaluating this and other federal, state, county and tribal programs. Consenting to share data will not affect your eligibility or participation for services.
If you only authorize limited data to be shared (Data shared/sent/stored will not include name or address) initial here: _____

_____ **Client Initials** I have received the Notice of Privacy Practices and have been informed of my rights.

Signing this form means that you understand the following:

- I am giving permission for the written and/or verbal release and exchange of my information as indicated above.
- If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting.
- This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____
- I may cancel this consent at any time by writing to any agency listed above.
- I may cancel this consent with written notice at any time, but this written notice will not affect information the agency has already requested or released.
- My information will be released to protect my health/safety and/or the health/safety of others as required by law.
- Information released by an agency is no longer controlled by that agency and could be re-disclosed if it is no longer protected by federal or state privacy laws.
- PCPH/NMPH will bill my insurance prior to the use of grant funds to cover the cost of services. I request payment of authorized Medicaid, Minnesota Care, Health Insurance and grant benefits and hereby assign benefits payable on my behalf directly to PCPH/NMPH.

Client Signature:	Client Initials:	Date:
Parent, Guardian or Legally Authorized Representative Signature:	Relationship to Client:	
Witness:	Date:	