Steele County Community Corrections
121 East Mill Street
Owatonna, MN 55060

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STEELE COUNTY COMMUNITY CORRECTIONS
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name: **DOB:** **Client #:**

I authorize Steele County Community Corrections to √ **(send)** √ **(receive)** the following private data protected under Minn. Stat. 13/MN Medical Records Act/MN Patient Bill of Rights/FDA/HIPAA to/from the following agency/individuals:

Individuals: _____ Agency: _____

_____ _____

_____ _____

___ Intake Summary
___ Psychological Reports
___ Progress Reports
___ Discharge Summary
___ Psychiatric Evaluation
___ Verbal/Written Information
___ Chemical Dependency Assessment
___Other: _____
___ Psychological testing results
___ Academic Reports Attending Grade IEP
___ Data pursuant to dates: __/__/__ thru __/__/__

The above information will be used for the following purposes:

___ Pre-sentence investigations, pre-dispositional reports, and supervision of client
___ Other (specify): _____

This authorization **expires at the end of probation/supervised release** or this sooner date: ___/___/___.

This authorization does extend to information placed in my record after the date I sign this form.

I understand that my records to be released may contain information regarding substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information.

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that Steele County Community Corrections has already taken action in reliance on it.

I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient to the Courts, attorneys for the parties in this case, and agencies providing assessments and/or programming for this client and no longer be protected.

I understand that I may refuse to sign this consent, if I so desire, and that my supervision may not be conditioned on my signing this consent, but refusal may have consequences that have been explained to me.

Acknowledged and agreed to by the individual/client to whom the protected health information pertains:

_____ ___/___/___
Client Signature: Date

OR Acknowledged and agreed to by the client's representative, who is empowered to act on his/her behalf by reason of:

_____

_____ ___/___/___
Client's Representative/Parent/Legal Guardian Date

I **revoke** the release of information consent: _____ ___/___/___
Signed Date