

ISANTI COUNTY FAMILY SERVICES
Oakview Office Complex
1700 East Rum River Drive South, Suite A
Cambridge MN 55008

CONSENT FOR RELEASE OF INFORMATION

I. TYPE AND USE OF INFORMATION

A. I authorize Isanti County Family Services and ISANTI COUNTY PROBATION SERVICES
_____ to disclose or exchange the following information:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Chemical Dependency Reports | <input type="checkbox"/> Psychiatric Evaluation/Treatment |
| <input checked="" type="checkbox"/> Probation Records | <input type="checkbox"/> Discharge Summary/Aftercare Plan |
| <input type="checkbox"/> Educational/School Records | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Juvenile Court Records | <input type="checkbox"/> Initial Treatment Plan |
| <input type="checkbox"/> Medical History and Treatment | <input type="checkbox"/> Violation of Continued Use of Chemicals |
| <input type="checkbox"/> Psychological Evaluation/Treatment | <input checked="" type="checkbox"/> Other: <u>Assessment Results</u> |
| <input type="checkbox"/> Isanti County Court/Ct Administration | <input checked="" type="checkbox"/> Other: <u>Recommendations</u> |

B. I realize that this information is being disclosed for the following purposes: TO COMPLY WITH COURT ORDER

C. I further realize that the conditions, date or event upon which this consent expires are as follows: _____

II. UNDERSTANDING

- A. I understand that the information will be used for the purpose specified and will not be disclosed to other sources unless specifically authorized by law.
- B. I understand that I may refuse to release this information and the consequences of this refusal have been explained to me.
- C. I understand that I may revoke this consent at any time, except in pursuant to court order, not retroactively, and that such revocation must be in writing.
- D. I understand that the information to be exchanged will be treated as private or confidential as governed by Minnesota Government Data Practices Act, MS13.01 to 13.88.
- E. I understand that this authorization will permit two-way telephone communication between the agencies or individuals listed above.
- F. I understand that this information may not be disclosed to anyone else other than those agencies or individuals listed above unless written permission is provided.
- G. I understand that my records will be filed in the agency's normal and customary manner according to county procedure.

III. EXECUTION

This consent will automatically expire one year from the date of my signature unless other conditions for expiration as stated above have been met at an earlier date.

- A. Client Name: _____ D.O.B. _____
- B. Client Address: _____
- C. Client Signature: _____ Date: _____
- D. Witness Signature: _____ Date: _____
- E. Parent Signature: _____ Date: _____
(If client is a minor)
- F. Social Security Number: _____