Polk-Norman-Mahnomen Community Health Services
Polk County Public Health (PCPH), 721 S. Minnesota St, PO Box 403, Crookston, MN 56716
Norman-Mahnomen Public Health (NMPH), 15 E 2nd Ave. Rm 107, Ada, MN 56510 / 115 Madison Ave., PO Box 226, Mahnomen, 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:

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

- Initial 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:

☐	Polk County Public Health/Norman-Mahnomen Public Health/WIC	☐	School Districts:
☐	Human/Social Services:	☐	Special Education:
☐	Hospitals:	☐	Community Action Agency: Tri-Valley Opportunity Council, Inc.
☐	Clinics:	☐	Community Action Agency: MAHUBE-OTWA
☐	Pharmacies:	☐	Clay County Public Health
☐	Mental Health Clinics/Providers:	☐	Other:
☐	Nurse Family Partnership National Service Office (NFP NSO)	☐	Other:
☐	Minnesota Department of Health (MDH)**		
☐	Other: Family Members (specify):		
☐	Other: Father of Child (specify):		

- Initial 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) Evaluation requests information regarding the entire time enrolled in a FHV program. This portion of the consent will end after 18 months due to reporting responsibilities unless specifically canceled sooner.

____ **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.
- **As authorized by Minnesota Statutes, the CHIC HIE-Bridge Network or Relay Health Network allows authorized health care providers to quickly find the *location* of health information about me from participating providers.**
  - **OPT OUT: _____ Initial here to opt out of this locator service.**

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