Metro Social Services, Inc.
345 University Avenue, Suite A
St. Paul, MN 55103
651.647.0647 Fax: 651.647.1075

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Client Name _____ Date of Birth _____

I authorize **Metro Social Services, Inc:** To exchange with _____

_____

This information will be used and/or disclosed for the following purposes:

☐ To enhance the services provided to me by MSSI: community support services staff and consultants

☐ Individuals involved in your care or payment for your care ☐ To obtain information from school/teachers as needed

☐ Other: _____

(*Research for treatment purposes may be conditioned upon a patient's signing of this release. An authorization for research may exceed one year as provided in 45 C.F.R § 164.508(c)(v).

I authorize the release and exchange (both releasing and obtaining) of the following protected health information:

Medical:
☐ Medication History/Summary
☐ Medical Reports

Legal:
☐ Child Maltreatment Reports
☐ Court or Probation Records
☐ Letters/Reports/Affidavits

Mental Health:
☐ Assessment/Diagnostic Findings
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Discharge Summary

Chemical Dependency:
☐ History/Assessment Reports
☐ Treatment Records

School:
☐ Attendance Records
☐ Special Education Records
☐ Academic Records
☐ Pick student from school

Other:
☐ Telephone Contact
☐ Specify: _____
☐ Specify: _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, child abuse and treatment for alcohol and drug abuse.

I understand that authorizing the release of this health information is voluntary. I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to the Clinical Director. I understand that stopping this authorization will not apply to information that has already been released or disclosed.

Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal privacy rules.

_____ _____
Client Signature Date Signed

_____ _____
Address Phone Number