RELEASE OF INFORMATION AND INFORMED CONSENT FOR SERVICES

I. Identifying Information

Client Full Name: _____ **DOB:** _____

Physical Address: _____ **Phone:** _____

City/State/Zip: _____ **Phone(2):** _____

Alias/AKA(s): _____ SS#: _____

II. Release of Information

The Leech Lake Child Welfare Department is authorized to:

___ receive information from: Agency Name:

_X_ give information to: Agency Name: **LLCW-FOSTER CARE**

Specific description of information to be used or disclosed (check all that apply):

- ☐ Discharge or closing summary
- ☐ Laboratory reports_____
- ☐ Medical history/physical exam
- ☒ Social service records
- ☐ Progress reports
- ☐ Treatment records
- ☐ Emergency room reports
- ☐ Intake summary/Diagnostic Assessment
- ☐ Psychiatric evaluation
- ☐ Social history
- ☐ Psychological testing or evaluation
- ☐ Treatment plan or support plan
- ☐ Birth records
- ☐ School records, IEP, assessments, transcripts
- ☐ Immunization records
- ☐ Vocational reports
- ☐ Medication records
- ☒ Court records
- ☒ **SSIS – Social Serv. Info. Sys.**
- ☒ **BCA CRIMINAL RECORDS**
- **HUMAN SERVICES RECORDS**

Specific purpose of disclosure (check all that apply):

- ☒ Coordinate services
- ☐ Mental health assessment and counseling
- ☒ Other **FOSTER CARE LICENSING**
- ☐ Case management services
- ☐ Provide referrals

III. Informed Consent

You are being asked to give private information and consent for services to the Leech Lake Child Welfare Department. This information is being collected to maintain a written record of the services provided to you. You may refuse to supply the requested information.

I, _____, understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent at any time with written notice. I understand that canceling this consent will not affect information the agency has already requested or released. I understand that those who receive my records under this release may share it with others only by written consent. I understand that Child Welfare Administration, Child Protection/Family Services, Family Services Urban Office, Family Preservation, Child Welfare Commission, and Foster Care Licensing are all programs within the Child Welfare Department and are permitted to share my private information related to services provided to me without a release of information authorization.

This authorization will expire on:_____ or one year from the date I sign it.

_____ _____

Signature of individual authorizing release — Date

_____ _____

Signature of parent, guardian or authorized representative — Date

NOTE: *Everyone 13(+) in the home & sub-care providers* ***MUST*** *complete ROI*

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