



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:

give information to: Agency Name: LLCW-FOSTER CARE

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

- | | |
|---|---|
| <input type="checkbox"/> Discharge or closing summary | <input type="checkbox"/> Psychological testing or evaluation |
| <input type="checkbox"/> Laboratory reports _____ | <input type="checkbox"/> Treatment plan or support plan |
| <input type="checkbox"/> Medical history/physical exam | <input type="checkbox"/> Birth records |
| <input checked="" type="checkbox"/> Social service records | <input type="checkbox"/> School records, IEP, assessments, transcripts |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Immunization records |
| <input type="checkbox"/> Treatment records | <input type="checkbox"/> Vocational reports |
| <input type="checkbox"/> Emergency room reports | <input type="checkbox"/> Medication records |
| <input type="checkbox"/> Intake summary/Diagnostic Assessment | <input checked="" type="checkbox"/> Court records |
| <input type="checkbox"/> Psychiatric evaluation | <input checked="" type="checkbox"/> SSIS – Social Serv. Info. Sys. |
| <input type="checkbox"/> Social history | <input checked="" type="checkbox"/> BCA CRIMINAL RECORDS |
| | HUMAN SERVICES RECORDS |

Specific purpose of disclosure (check all that apply):

- | | |
|--|---|
| <input checked="" type="checkbox"/> Coordinate services | <input type="checkbox"/> Case management services |
| <input type="checkbox"/> Mental health assessment and counseling | <input type="checkbox"/> Provide referrals |
| <input checked="" type="checkbox"/> Other <u>FOSTER CARE LICENSING</u> | |

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

16126 John Moose Dr NE Ste-120 / PO BOX 967 Cass Lake, MN 56633

Phone: (218) 335-8270