

# Consent to Release and Exchange Personal Information Between Your Care Team Agencies

**1. Purpose of the exchange of information: Coordination of your care**

This release will permit the individuals and agencies you choose, to work together in a confidential, professional manner to meet your wellness needs.

**2. Your basic information:**

<b>Name</b> <small>First MI Last AKA</small>	<b>Date of Birth</b>
<b>Address</b>	

**3. Type of information to be exchanged as it pertains to helping the team assist in your wellness:**

Cross out and initial any item if you do not give this permission:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• History and Physical</li> <li>• Diagnoses</li> <li>• Medications</li> <li>• Progress Notes</li> <li>• Care Plan or Treatment Plan</li> <li>• Mental and Chemical Health Diagnoses, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications</li> </ul> | <ul style="list-style-type: none"> <li>• School IEP &amp; Assessments</li> <li>• Immunizations</li> <li>• HIV/Aids testing</li> <li>• Emergency and Urgent Care Reports</li> <li>• Discharge/Treatment Summary</li> </ul> |
|---|---|

**4. Identify which of the following agencies and/or individuals are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above**

(Check the members to whom you'd like to give permission):

<input type="checkbox"/>	Boundary Waters Care Center	<input type="checkbox"/>	Northwoods Hospice Respite Partners
<input type="checkbox"/>	Center for Rural Mental Health Studies	<input type="checkbox"/>	Project Care Free Clinic
<input type="checkbox"/>	Ely Bloomenson Community Hospital	<input type="checkbox"/>	Range Mental Health Center
<input type="checkbox"/>	Ely Community Resource	<input type="checkbox"/>	St. Louis County Public Health & Human Services
<input type="checkbox"/>	Essentia Health-Ely Clinic	<input type="checkbox"/>	St. Mary's Hospice and Palliative Care
<input type="checkbox"/>	ISD 696	<input type="checkbox"/>	Northern Lights Clubhouse
<input type="checkbox"/>	ISD 2142	<input type="checkbox"/>	Vermilion Community College
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

**5. When you sign this form it shows that you understand the following:**

- You are giving permission for the written and/or verbal release and exchange of your personal information as indicated in section 3, between those named in section 4.
- No one will deny you help if you do not want us to share your personal information
- If you allow the release and exchange of information, this consent will expire in one year and/or you may cancel this consent at any time in writing to any agency listed above.
- If you submit a request to stop sharing your information, the request does not apply to information already shared before the time of your request.
- We shall release your information to protect the health/safety of you and/or others when 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.

Signature	Date
Legal Representative Signature	Print Name/Relationship
	Date

Location of Original:  
Copies sent to: