Clear Form

Minnesota Department of **Human Services**

Social Services Authorization for Release of Information

DHS-3377-ENG 9-11

I, _____ authorize
(Name of individual authorizing release*)

_____
(Name of individual or entity maintaining data about me or dependent family members)

to disclose private data about me to _____.
(Name of individual(s), or entities to receive the information)

*Provide the following information if required to identify this individual from other similar names in agencies' files:			
ADDRESS			CLIENT NUMBER
CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER
BIRTH DATE	OTHER IDENTIFYING INFORMATION		

Provide the following information:

- ☐ Discharge or closing summary
- ☐ Laboratory reports - List: _____
- ☐ Medical history/physical exam
- ☐ Social service records
- ☐ Progress reports
- ☐ Treatment records
- ☐ Emergency room reports
- ☐ Admission/intake summary/diagnostic Assessment
- ☐ Psychiatric evaluation
- ☐ Social history
- ☐ Psychological testing or evaluation
- ☐ Treatment plan or community support plan
- ☐ Birth records
- ☐ School records, IEP, assessments, transcripts
- ☐ Immunization records
- ☐ Vocational reports
- ☐ Medication records
- ☐ Court records
- ☐ Chemical dependency evaluation
- ☐ Other: _____

The information is required to:

- ☐ Continue evaluation or treatment
- ☐ Coordinate services
- ☐ Determine eligibility for case management services
- ☐ Other: _____

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked for this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be shared/released unless the law otherwise allows it
- I may stop this authorization with written notice at any time, but that this written notice will not affect information the agency has already shared/requested.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization ends _____, or one year from the date I sign it, unless the law allows for a longer period.
(Date)

SIGNATURE OF INDIVIDUAL AUTHORIZING RELEASE	DATE
SIGNATURE OF WITNESS (if required)	DATE
SIGNATURE AND RELATIONSHIP OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE (if required)	DATE

Note to agencies using this form: Prior to having this form signed you must communicate the consequences of giving informed consent to the individual. Provide a signed (executed) copy of the authorization to the individual who consents to release personal information.

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA5 (5-09)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.