FRASER
Special needs ★ Bright futures

CONSENT FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

(Please complete this form in black or blue ink)

Client Name:_____ Date of Birth: _____

I/We, the undersigned, hereby authorize **Fraser** to (check all that apply):

☐ Exchange Information with: ☐ Release Information to: ☐ Obtain Information from:

Name of Person or Agency	Phone	Fax

Attention (Specific person desired if not noted above)	Title	Phone	e-mail

Street Address	City	State	Zip Code

PLEASE DRAW A LINE THROUGH ANY INFORMATION/PURPOSES LISTED BELOW WHICH YOU DO NOT WANT RELEASED

Information Requested from Agency:

- Family Information
- Immunization Records
- Medical History
- Individual Education Plans
- Evaluation and/or Progress Reports
- Assessment Data
- Psychological/Standardized Testing
- Discharge Summary
- Therapy Authorization
- Transportation Authorizations
- Phone Contact
- Other: _____

Information to be Released by Fraser:

- Enrollment/Discharge
- Family Information/Update
- Individual Education Plans
- Evaluation Reports
- Consultation Reports
- Progress Reports
- Phone, e-mail or other direct Contact
- Other: _____

The purpose of this Request:

- Continuing Care/Ongoing Treatment
- Educational Planning and Service Provision
- Application for Insurance
- Evaluation/Assessment Consultation
- Disability Determination
- Other, please describe: _____

I/We understand that my/our records are protected under State and Federal confidentiality and data privacy regulations and cannot be disclosed without my/our written consent unless otherwise provided for in the regulations. I/We understand that I/We may revoke this consent at any time and that in any event this consent expires automatically as noted below. I/We understand that information exchanged is limited to staff whose work assignments reasonably require access to my/our data within the purpose specified in the services provided.

Fraser cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Fraser from liability resulting from a redisclosure by the recipient.

Date*: _____ *Consent expires 1 year from Date (unless otherwise noted).

X_____ _____

Signature of Client/Parent/Guardian Relationship to Client

Please return form to: _____

- ☐ Fraser Residential Living, 2400 W 64th Street, Minneapolis, MN 55423, fax 612-861-6050
- ☐ Fraser at Hennepin Square, 2021 E. Hennepin Ave, Suite 402, Minneapolis, MN 55413, fax 612-767-5176
- ☐ Fraser Minneapolis, 3333 University Ave, Minneapolis, MN 55414, fax 612-728-5301
- ☐ Fraser School, 2400 W 64th Street, Minneapolis, MN 55423, fax 612-861-6050