FRASER
Special needs ★ Bright futures®

AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

(Please complete this form in Black or Blue ink)

Client Name: _____ Date of Birth: _____ Case# _____

I/We, the undersigned, hereby authorize **Fraser** to (**check all boxes 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

_____

Street Address City State Zip Code

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

*Information **to obtain** 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
- Individual Service Plan/Coordinated Service and Support Plan Addendum
- Other: _____

*The **purpose** of this request is:*

- 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 in writing 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 re-disclosure 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 re-disclosure by the recipient.

Fraser will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I/We do not have to consent to the release of this information; however, I understand that not doing so may affect this program's ability to provide needed services to me.

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

X _____ _____

Signature of Client/Parent/Guardian **Relationship to Client**

Please return form, attention: _____ to:

- ☐ Fraser Health Information Management, 3333 University Ave SE, Minneapolis, MN 55414, fax 612-728-5301
- ☐ Fraser Home & Community Supports/Independent Living, 6328 Penn Ave S., Richfield, MN 55423, fax 612-767-5176
- ☐ Fraser Residential, 2400 W 64th Street, Minneapolis, MN 55423, fax 612-861-6050
- ☐ Fraser School, 2400 W 64th Street, Minneapolis, MN 55423, fax 612-861-6050