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, by sharing information and communications as needed, to meet your wellness needs and goals.

2. Your basic information:

Name First MI Last AKA	**Date of Birth**
Address	

3. Type(s) of information to be exchanged if necessary to coordinate your care and improve your wellness:
Cross out *and* initial any item if you *do not* give this permission**:**

- **History and Physical**
- **Diagnoses**
- **Medications**
- **Progress Notes**
- **Care Plan or Treatment Plan**
- **School IEP & Assessments**
- **Immunizations**
- **HIV/Aids testing**
- **Emergency and Urgent Care Reports**
- **Discharge/Treatment Summary**
- **Mental and Chemical Health Diagnoses, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications**

4. Identify which of the following agencies are important to your care coordination 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):

	Boundary Waters Care Center			Northwoods Partners
	Carefree Living			Range Mental Health Center
	Ely Area Food Shelf			Scenic Rivers Health System
	Ely Bloomenson Community Hospital			St. Anthony's Catholic Church & St. Pius X
	Ely Community Health Center			St. Louis County Public Health & Human Services
	Ely Community Resource			Vermilion Community College
	Essentia Health			Well Being Development/ Northern Lights Clubhouse
	Housing & Redevelopment Authority-Ely			Other:
	ISD 696: Ely Public Schools			Other:
	ISD 2142: St. Louis County Schools			Other:
	NHS-Northstar Specialized Services			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 described in section 3, between agencies 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, or you may cancel this consent at any time in writing to any agency to which you authorized us to share your information on your original, signed consent form.
- 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.
- If required by law, we will release your information to protect your health and safety or that of others
- We cannot guarantee that the recipient organization will not redisclose your health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of your health information.
- When you authorize a release of information to any of the above-listed organizations, you are entitled to a copy of that authorization. You are also entitled to inspect or copy any of your health information that has been disclosed, although you may be assessed reasonable fees for copying services.

Signature		Date
Legal Representative Signature	Print Name/Relationship	Date

ROI final 416/22

Location of Original:
Copies sent to: