# *WINONA COUNTY RE-ENTRY ASSISTANCE PROGRAM*
# *CONSENT AND RELEASE OF INFORMATION FORM*

***Revised 12.1.19***

I,_____, D.O.B. _____, have agreed to receive services from the Winona County WRAP Program. I understand that signing this Consent and Release Form is a condition of my participation in the Winona County WRAP Program.

## SECTION 1: ENTITIES/INDIVIDUALS WHO ARE AUTHORIZED TO EXCHANGE INFORMATION ABOUT ME

A. I authorize the below entities/individuals to disclose and exchange information

❑ **I AUTHORIZE ALL OF THE BELOW LISTED ENTITIES/INDIVIDUALS TO DISCLOSE AND EXCHANGE INFORMATION**

**Law Enforcement**
- ❑ Winona County Sheriff's Dept
- ❑ Winona Police Department
- ❑ Department of Public Safety
- ❑ Bureau of Criminal Apprehension
- ❑ _____

**Court & Community Services/Corrections**
- ❑ Winona County Court Administration
- ❑ Treatment Court of Winona County
- ❑ Winona County Jail Intake Worker
- ❑ Minnesota Dept. of Corrections
- ❑ Winona County Health & Human Services
- ❑ WRAP Program Personnel
- ❑ Veteran's Treatment Court

**Medical/Mental Health**
- ❑ Advanced Correctional Healthcare
- ❑ Winona Health
- ❑ Hiawatha Valley Mental Health Center
- ❑ Counseling Associates
- ❑ Acumen Counseling Services, LLC
- ❑ Common Ground Treatment Services
- ❑ Empower, CTC
- ❑ _____

**Vocational/Financial**
- ❑ Winona Workforce Center
- ❑ Social Security Administration
- ❑ Volunteer Services
- ❑ _____

**Other**
- ❑ Attorney:_____
- ❑ _____

B. With the below entities/individuals

❑ **I AUTHORIZE ALL OF THE BELOW LISTED ENTITIES/INDIVIDUALS TO DISCLOSE AND EXCHANGE INFORMATION**

**Law Enforcement**
- ❑ Winona County Sheriff's Dept
- ❑ Winona Police Department
- ❑ Department of Public Safety
- ❑ Bureau of Criminal Apprehension
- ❑_____

- ❑ Winona County Court Administration
- ❑ Treatment Court of Winona County
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- ❑ _____

**Vocational/Financial**
- ❑ Winona Workforce Center
- ❑ Social Security Administration
- ❑ Volunteer Services
- ❑ _____

**Other**

Attorney:_____
- ❑ _____

Client Initials:_____

## SECTION 2: INFORMATION TO BE EXCHANGED

⟹ ❑ **I AUTHORIZE RELEASE OF ALL OF THE INFORMATION LISTED BELOW**

❑ Admission/Intake
❑ Bail Evaluation Forms
❑ Behavioral Health Notes
❑ Charges/Criminal Complaints
❑ Chemical Health Programming Records
❑ Chemical Use Assessment/Recommendations
❑ Court Records
❑ Criminal Complaint
❑ Criminogenic Screening/Assessments (ex LS-CMI, ORAS-CSST)
❑ Diagnostic Assessment/Recommendations
❑ Discharge Summary
❑ Educational Records
❑ Emergency Room Records
❑ Other:_____

❑ Financial Status/Income Records
❑ Health Insurance Information
❑ Human Services Records
❑ Jail Admit/Discharge Records
❑ Laboratory Records/Tests
❑ Medical History/Physical Exam
❑ Medication Records
❑ PBT, Blood Test and Urinalysis Results
❑ Presentence Investigation Reports
❑ Progress Notes/Case Notes
❑ Psychiatric Evaluation
❑ Psychological Testing/Evaluation
❑ Treatment/Community Support/Case Plans
❑ Other:_____

❑ I specifically authorize the release of records pertaining to alcohol abuse or test results, drug abuse or test results and mental health.

❑ I authorize representatives from the entities/individuals authorized in Section 1 to discuss the information disclosed above with each other.

## SECTION 3: PURPOSE OF RELEASE

⟹ ❑ **I AUTHORIZE RELEASE OF INFORMATION FOR ALL PURPOSES LISTED BELOW**:

❑ To coordinate referrals and placement
❑ To coordinate services
❑ To continue evaluation or treatment
❑ To determine availability for funding
❑ research & analysis purposes (aggregate data)
❑ _____

## SECTION 4: ACKNOWLEDGEMENT

I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information and any known consequences of this release. The information to be released is private, and any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minn. Stat. 1982 Chap. 13). I understand that State and Federal privacy laws protect my records. My records can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, I may not be eligible to receive the service I am requesting. I may cancel this consent with written notice at any time, but that this written notice will not affect information about me that has already been requested or released. I understand that those who receive my records under this release may share it with others. I also understand that once the information is shared with others, it is no longer protected by this authorization. I have been informed of my right to refuse to release this information. I received and reviewed a Notice of Privacy Practices/Rights. I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire within one (1) year after the date of my signature. A photocopy of this release is as valid as the original.

⟹ Participant's Signature _____ DATE _____

Printed Name:_____