



**WINONA COUNTY REENTRY ASSISTANCE PROGRAM+
CONSENT AND RELEASE OF INFORMATION FORM**

Revised 6.30.21

⇒ 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

- Winona Community Hub
- 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
- _____

Court & Community Services/Corrections

- Winona County Court Administration
- Treatment Court of Winona County
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Medical/Mental Health

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- Empower, CTC
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Vocational/Financial

- Winona Workforce Center
- Social Security Administration
- Volunteer Services
- _____

Other

- Winona Community Hub
- Attorney: _____

Client Initials: _____ ←⇒

SECTION 2: INFORMATION TO BE EXCHANGED



I AUTHORIZE RELEASE OF ALL OF THE INFORMATION LISTED BELOW

- | | |
|---|---|
| <input type="checkbox"/> Admission/Intake | <input type="checkbox"/> Financial Status/Income Records |
| <input type="checkbox"/> Bail Evaluation Forms | <input type="checkbox"/> Health Insurance Information |
| <input type="checkbox"/> Behavioral Health Notes | <input type="checkbox"/> Human Services Records |
| <input type="checkbox"/> Charges/Criminal Complaints | <input type="checkbox"/> Jail Admit/Discharge Records |
| <input type="checkbox"/> Chemical Health Programming Records | <input type="checkbox"/> Laboratory Records/Tests |
| <input type="checkbox"/> Chemical Use Assessment/Recommendations | <input type="checkbox"/> Medical History/Physical Exam |
| <input type="checkbox"/> Court Records | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Criminal Complaint | <input type="checkbox"/> PBT, Blood Test and Urinalysis Results |
| <input type="checkbox"/> Criminogenic Screening/Assessments
(ex LS-CMI, ORAS-CSST) | <input type="checkbox"/> Presentence Investigation Reports |
| <input type="checkbox"/> Diagnostic Assessment/Recommendations | <input type="checkbox"/> Progress Notes/Case Notes |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Educational Records | <input type="checkbox"/> Psychological Testing/Evaluation |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Treatment/Community Support/Case Plans |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

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

X 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:

- | | |
|--|--|
| <input type="checkbox"/> To coordinate referrals and placement | <input type="checkbox"/> To determine availability for funding |
| <input type="checkbox"/> To coordinate services | <input type="checkbox"/> research & analysis purposes (aggregate data) |
| <input type="checkbox"/> To continue evaluation or treatment | <input type="checkbox"/> _____ |

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 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 and an electronic signature is as valid as an ink signature.



Participant's Signature _____ DATE _____
Printed Name: _____