JEWISH FAMILY SERVICE OF ST. PAUL

CONSENT FOR RELEASE AND SHARING OF INFORMATION

Name of Client: _____ Date of Birth: _____

I, the above-named client, authorize my case manager and other staff of Jewish Family Service of St. Paul to disclose and request/obtain information from my records indicated below for the purpose of providing care coordination with the following individuals/organizations:

1. _____
2. _____
3. _____
4. _____

Specifically, the information to be disclosed is:

_____ Psychological information
_____ Social/family history
_____ Education summary
_____ Chemical dependency issues
_____ Other _____
_____ Psychometric testing
_____ Medical reports
_____ Case notes
_____ Employment history

I authorize the use of a fax by mail of this form for the release or disclosure of the information described above.
_____ Yes _____ No (check one)

I authorize the use of a photocopy by mail of this form for the release or disclosure of the information described above.
_____ Yes _____ No (check one)

I understand that I may revoke this consent in writing at any time. If not withdrawn, this authorization expires one year from the date of signing. In accordance with the Minnesota Data Privacy Act, neither agency will further disclose any information without my consent.

REDISCLOSURE STATEMENT: I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy rules.

EXPIRATION DATE: This authorization will expire one year from the date signed.

_____ Date _____
Client's signature

_____
Signature of parent, guardian or responsible person

Additional comments here: _____

_____

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jfssp.org

An affiliate agency of the St. Paul Jewish Federation and the Greater Twin Cities United Way