AUTHORIZATION FOR THE RELEASE OF INFORMATION

Participant's Name: **Birth Date:**

Legal Guardian Name: **Telephone Phone:**

Address:

****

I authorize: **Salem Inc 2507 Bryant Ave N. Minneapolis, MN 55411. (612) 522-2951**

and the Authorized user to:

- ☐ **Release information On behalf of authorized Salem Inc. Staff**
- ☐ **Primary**_____
- ☐ **Obtain information from(fill in the blank)**_____

The purpose of:

- ☐ Enrollment in Salem Inc. Services
- ☐ To allow for professional consultation
- ☐ To provide staff with a better understanding of your and/or your child's needs
- ☐ Assessment for services through Hennepin County Probation – Family Services Unit
- ☐ Assessment for services through Hennepin County Public Health
- ☐ Other: _____

Academic Support

- ☐ Pathways to Success
- ☐ Family Group Conferencing **(**Legal Rights Ctr**)**
- ☐ Obtain IEP/504 3b
- ☐ Legal Rights Ctr (Family Group Counseling) VOA, Takoda Prep, El Colegio, Brooklyn Ctr Early College Academy, Bloomington Career and College Academy)
- ☐ Other: _____

Mental Health Services

- ☐ Mobile Assessors
- ☐ Front Door Services (Voluntary Mental Health Case Mgmt)
- ☐ Mental Health Navigator
- ☐ North Point/HCMC/Hennepin Co. Mental Health Ctr
- ☐ Mobile Mental Crisis Resources
- ☐ Children's Mental Health & JP Coordinated Case Mgmt
- ☐ Other: _____

To Third Parties: Upon request by the client, in accordance with state statutes, this agency is required to provide access for the client to the information contained on this request form or obtained or supplied as a result of this request.

The following information is requested

- ☐ Academic/Attendance Records
- ☐ School Disciplinary Records
- ☐ School Access such as Parent Portal/Powerschool
- ☐ Face Sheet from School Interface with picture, name of school and or ID
- ☐ School ID
- ☐ State ID
- ☐ Financial/MFIP/EA Records
- ☐ Hennepin County Juvenile Court Records
- ☐ Mental/Chemical Health Records
- ☐ Hennepin County Public Health Records
- ☐ Authorization to Speak to Case Worker: (Name: _____Phone: _____Case #: _____)
- ☐ Other: _____

The consequences of giving informed consent must be communicated to the individual before affixing his/her signature

To Clients: Your records are protected by state and federal privacy regulations and can not be disclosed without your prior written consent. All requested information/documents will be used for the purposes of determining eligibility, program planning and providing services to your family /children. I understand that I may submit a written request to revoke this consent at any time. I also understand that one year from the signed date or upon fulfillment of the above stated purpose(s), whichever comes earlier, this consent will automatically expire without my express revocation.

Expiration Date	Month:	Day:	Year:

In no event shall this consent be valid for more than one year from the date of my signature below.

_____ _____

Applicant Signature: **Date:**