PEOPLES DEVELOPMENT SERVICES
St. Paul Office: 665 Snelling Ave N, St Paul, MN
Minneapolis Office: 3617 E. Lake Street Ste A-3, Minneapolis, MN 55406
Phone: 612-332-9124 Fax: 612-332-9867 Email: contact@pdsminn.org
www.pdsminn.org

Release of Information Consent Form

I,_____, Birthday_____/_____/_____ authorize Peoples Development Services (PDS) to:

☐ Exchange with the following individual(s) or entity(ies):_____
☐ Obtain from the following individual(s) or entity(ies):_____
☐ Release to with the following individual(s) or entity(ies):_____

The Following information:
☐ Social Security Disability ☐ Bio/Psyco/Social ☐ Progress Notes/Treatment Plan Review
☐ Psychological Information ☐ Rule 25 Assessment & Referrals ☐ Housing & Employment Info
☐ County Benefits & MNsure ☐ Discharge/Treatment Summary ☐ Other:_____

The purpose for this disclosure is:_____

This consent expires automatically twelve (12) months from the date this consent is signed, unless revoked by me.
I understand that my records are protected under the Minnesota Government Data Privacy Act (Minn. Stat. Chapter 13), the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162, and 164), and other applicable state and federal privacy laws. I understand that this information cannot be released without my written consent, unless otherwise authorized by law, and that I am under **NO OBLIGATION** to release it. I understand that I may release all, some, or none of the information. I understand that if there is a child protection hearing, the information collected from me will become public if submitted in a report to the court or if introduced as evidence pursuant to Minnesota Rules 44.01 and 44.02 of the Rules of Juvenile Procedure, except for the data specifically listed in Rules 8.01 through 8.08 of the Minnesota Rules of Juvenile Procedure. I understand that I have a right to see the information and have a copy of it. I may revoke this Consent at any time in writing, however, revocation will not pertain to data released or obtained prior to the County's receipt of the written revocation notice at one of the addresses noted above. Unless I revoke my consent sooner, my permission to allow the release of this information will automatically expire one (1) year from the date I sign this release.
I understand that in accordance with 45 CFR part 164.508, subd. c (2) (iii), you are informing me that the individual(s) or entities whom you are authorized to disclose my information to may not be subject to the same privacy rules as PDS and there may be the potential for redisclosure of the private information. I understand that my eligibility to receive benefits from PDS Social Services will not be affected if I refuse to sign this release. However, I also understand that if I refuse to sign this Consent, it could affect the County's ability to determine what services I need or am qualified to receive.

Date:_____/_____/_____ Client Signature:_____

Person Requesting Release:_____

_____ Parent/Guardian:_____
Witness *(If client under 18 or under legal Guardianship)*

Please fax or email the consent to form: Fax: 612-332-9867 or contact@pdsminn.org