

# Consent for Release of Confidential Information



I, \_\_\_\_\_, parent/guardian of, \_\_\_\_\_,

\_\_\_\_\_ D.O.B. \_\_\_\_\_ Address \_\_\_\_\_

hereby authorize PORT Group Homes to obtain and exchange confidential information regarding the above named client. The purpose for which this information will be used is to coordinate comprehensive treatment and treatment planning. The agencies with which information may be exchanged are listed below. **(Please, initial the white boxes. The initialed boxes authorize exchange of information.)**

Agencies	All Information	Medical / Diagnostic	Authorized to Transport Child
_____ County Court Services			
_____ County Social Services			
ADAPT outpatient chemical dependency treatment			
Brainerd Medical Center			
Brainerd School District #181			
CARE outpatient chemical dependency treatment			
The Counseling Center			
Core Professional Services			
Crow Wing County Family Services Collaborative			
Dr Richard Carlson, Dental			
Good Neighbors Home Health Care			
Holistic Psychological Services			
Lake Country Dental			
Lakes Area Counseling			
Lutheran Social Services			
Medicine Shoppe			
Northern Pines Mental Health Center			
Nystrom's and Associates			
School District #_____ (home school)			
St. Joseph's Medical Center			
Other:			
Other:			

I understand that I have a right to refuse to release this information, and I understand my consent is voluntary. This consent may be revoked upon written notice, unless the information has already been released. This release automatically expires after one year. I further understand that a photocopy of this authorization will be accepted with the same authority as the original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Resident