Consent to Release Information

I, _____, authorize MoveFwd to exchange verbal and written information with the following:

Agency Release

Agency Name_____

Address_____

City_____ State_____ Zip Code_____

Phone (_____)_____

Contact person to release information to:

Name_____ Title_____

Relationship_____

I understand that this information may include a summary of:

____Phone consultations ____Chemical Health Evaluation

____Goals & Progress ____Diagnostic Evaluations & Recommendations

____Discharge & Treatment ____Psychological Testing

____Rental Needs & History ____Medication History

The purpose for the disclosure for the above information is:
____Facilitate involvement of significant others in services
____Coordination of services with the above named provider(s)
____Advocacy in finding safe and secure housing

Other:_____

I understand that I have the legal rights and that confidential information about me or my family is protected by data privacy laws. This authorization is effective for twelve months from the date signed and may be revoked at any time by written request to the Program Director at MoveFwd. Disclosure of information can be verbal or in written reports.

Participant's Printed
Name_____Date_____

Participants
Signature_____Date_____

MoveFwd Staff_____Date_____

Upon completion of this form, please save and submit to : rachelyoung@movefwdmn.org