MNDSA
Minnesota Disability Support Alternatives
9705 45th Avenue North #41982 | Plymouth, MN 55442
Phone: 612-470-1585 | Fax: 1-651-560-5578 | main@mndsa.org | www.mndsa.org

AUTHORIZATION TO RELEASE INFORMATION

SECTION ONE

Name:	Previous Names:
Date of Birth:	PMI:
Address:	
Phone:	Email:

SECTION TWO

I am requesting information be released to, and exchanged with (verbal and written), **Minnesota Disability Support Alternatives** from the following:

State of Minnesota	**Case Manager/County:**
Phone:	Phone:
Email:	Email:
Other (Ex. Family/Friend):	

SECTION THREE

The following information is to be released:

- **Health-related information,** that includes diagnoses and accommodations needed.
- Government information related to **Home and Community Based Waivers**, that includes diagnoses, service authorization, and any other information required for billing as a Minnesota Health Care Provider.
- Insurance coverage information

SECTION FOUR

This release includes both written and oral information. By signing this form, you are giving the above permission to talk about the information described in this release.

SECTION FIVE

The purpose for releasing information is:

- **Coordination of services for the Self Advocacy Training and Support Program**
- **Minnesota Health Care Programs Billing for Self-Advocacy Training and Support Program**

SECTION SIX

I understand that by signing this form, I am requesting that the health and other relevant information specified in Section Three be sent to the third party, Minnesota Disability Support Alternatives. I may stop this consent at any time by writing to the facilities/organizations/individuals in Section Two. If they have already released the information based on my consent, my request to stop will not work for that information. **This consent will expire one year from the date the form is signed**.

Consumer Signature
OR Legally Authorized Representative: _____

Representative relationship to consumer: _____

Date Signed: _____