The Arc Minnesota
641 Fairview Ave N Suite 195
St Paul MN 55104

PERMISSION TO RELEASE OR OBTAIN INFORMATION

I allow The Arc Minnesota to release or obtain information about:

Me: _____
(Print Name)

From the individual, agency or company listed below:

_____

☐ **Send/share:** ☐ **Obtain from:** ☐ **Talk/exchange with:**

Information to be shared:

☐ _____. **Purpose**_____

☐ _____. **Purpose**_____

☐ _____. **Purpose**_____

I understand that my records are protected under State and Federal law and cannot be shared without my written permission unless otherwise provided for in the regulations. I also understand that I do not have to agree to release this information and understand that I will not be denied assistance for refusing to agree to release the information but it may affect how much the agency can help me.

I understand that I may cancel this permission at any time; however, this will not affect information released before I withdrew my consent. I also understand that this permission expires in one year from the date signed.

I understand that information disclosed to and received from the persons and organization named above will only be shared with organization staff that needs information to provide me services.

Any release of private information is not allowed except as authorized above. (MN Statutes 13.05)

_____
Signature Date

_____
Signature of person who explained this form and your rights

The Arc®
Minnesota