

**AUTHORIZATION  
FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, authorize Perspectives staff to obtain/release my records or my children's records, or to discuss my situation in regards to my or my children's participation in Perspectives programs with the following: **(draw a line through any unused blank space)**

AGENCY	CONTACT PERSON	PHONE NUMBER
_____	_____	_____
_____	_____	_____

REGARDING: Myself and my child/children: **(draw a line through any unused blank space)**

_____	_____
Print Child's Name	Date of Birth
_____	_____
Print Child's Name	Date of Birth
_____	_____
Print Child's Name	Date of Birth
_____	_____
Print Child's Name	Date of Birth

**The information to be obtained/exchanged/disclosed is:**

\_\_\_\_\_

\_\_\_\_\_

The purpose of this disclosure is for Perspectives staff to best serve and advocate for me and my child(ren).

I understand that my records may be protected by the Minnesota Data Privacy Act. Any information received by Perspectives shall remain confidential.

I understand that I have the right to refuse to supply the information requested, however, without this information, Perspectives may not be able to provide me with the services I am requesting.

I understand that I may revoke this consent at any time by written notice. Without a written notice to revoke this consent (unless information has already been released), this authorization will expire 12 months from the date of my signature.

I understand that this information will be shared only with staff or their consultants who need my information to assist in the administration of the program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date of birth \_\_\_\_-\_\_\_\_-\_\_\_\_\_

\_\_\_\_\_  
Staff/Witness Signature

\_\_\_\_\_  
Date