1800 Second Street NE, Minneapolis MN 55418 | 612-789-1236 | www.actg.org

AUTHORIZATION FOR ACCESS, RELEASE and USE OF EDUCATIONAL INFORMATION

This release will expire one year from today's date: _____

Client name: _____ Date of birth: _____

The person named above is or has been a client of A Chance to Grow, Inc. (hereafter referred to as ACTG). ACTG is required to keep personal information, identifying information, and records confidential. By signing below, clients allow ACTG to access, send, and/or use information from certain individuals or agencies named.

Educational Release:

◯ I do not authorize **ACTG** to request, send, or share my **educational information** at this time.

Date: _____

OR

◉ I hereby authorize **ACTG** to:

- request educational information from
- send information to
- discuss educational/health information with

School: _____

Case Manager and/or Teacher: _____

Address: _____

Phone/fax: _____

Scope of information to be released:

☐ All information regarding assessment, diagnosis, and treatment plan

☐ Other (please specify) _____

Authorization:

_____ _____

Client or Legal Guardian Signature Date

If not signed by client, indicate relationship of authorizing representative to client: _____

Please initial the following:

_____ I understand that this authorization is effective for the above requested and authorized educational information only.

_____ I understand that I have the right to inspect the information I am authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our privacy practices document.

_____ I understand I do not have to allow A Chance To Grow, Inc. to share my information and that signing a release form is completely voluntary. My refusal to sign this authorization will not affect my ability to obtain treatment except to the extent that the information being requested may assist ACTG in determining appropriate treatment.

_____ I understand that If I would like A Chance To Grow, Inc. to release information about me in the future, I will need to sign another written, time-limited release. This release is limited to the information contained in this document.

_____ I understand that information may be shared in person, by phone, fax, mail, or email. I understand that email is not confidential and can be intercepted and read by other people. Releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from ACTG.

_____ I understand that I may withdraw my consent to this release at any time in writing. ACTG may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

_____ I understand that records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

Authorization:

_____	_____	_____
Client or legal guardian Signature	Date	Printed name of client of legal guardian

If not signed by client, indicate relationship of authorizing representative to client: _____

(7/01/2018)