Phone: 1-866-333-2466

disabilityhubmn.org

AUTHORIZATION for RELEASE and EXCHANGE of INFORMATION

Client Name_____ DOB_____ SSN # _____

Address_____ State_____ Zip _____

I give permission for Disability Hub MN™ to obtain from, exchange with, or give information to:

- ☐ Family Member/Guardian:_____
- ☐ Conservator/Payee:_____
- ☐ Social Worker (Name and County):_____
- ☐ Financial Worker (County):_____
- ☐ Public Health Department (County):_____
- ☐ MN Department of Human Services:_____
- ☐ MN Department of Rehab Services:_____
- ☐ Primary Physician:_____
- ☐ Psychiatrist:_____
- ☐ Pharmacy:_____
- ☐ Other:_____

This information will be used to obtain my state and/or federal benefit information.

State and Federal privacy laws protect my records. I understand that my refusal to consent to the release of information for Disability Hub MN™ will prevent the disclosure of information. I understand that I have the right to inspect and copy the information that I authorized to be disclosed. I understand that I have the right to revoke this authorization in writing at any time.
If not revoked, this authorization will expire: **ONE YEAR FROM SIGNED DATE**.

_____ _____

Signature of Client, Guardian or Conservator Date

_____ _____

Signature of person informing rights Date

_____

Printed Name of Client, Guardian or Conservator

_____

Printed name of person informing rights