Hennepin County
Human Services and Public Health Department

INFORMATION DISCLOSURE NON-EPIC HSPHD CLIENTS

Tennessen Notice - Explanation of the use of information gathered for HSPHD

While you are receiving services from HSPHD you will be asked to give certain information about yourself, your family history, your living habits, your income and finances, and related information that is needed to assist in provision of services and/or benefits to you and your family. All of this information and any documents (case plans, assessments, etc.) will be kept in the HSPHD combined electronic record systems. Other information regarding charges for HSPHD services or payments for services may also be maintained in the HSPHD combined electronic record systems.

Minnesota law provides that this kind of information cannot be collected, used, stored, disseminated (released to others) without advising you of the manner in which this information is treated by HSPHD. You have received a copy of the HSPHD Notice of Privacy Practices that provides this information to you.

The law provides that you may refuse to give information to HSPHD. However, if you do refuse to provide information, the HSPHD staff may not know enough about you to provide the best care or coverage of that care through insurance, health plans or government programs. In some instances, if you do not provide certain information, HSPHD may not be able to provide services to you.

If you are under 18 and the nature of your services permits you to access services without parental consent, you may request in writing that no information about the services be given to your parent or guardian. You should be aware that HSPHD staff may provide information to your parent or guardian if it is determined that failure to inform a parent or guardian would seriously jeopardize your health or safety.

I understand that information about the services that I receive from HSPHD is part of HSPHD's combined electronic record system and is available for identity management and service and care coordination purposes by other HSPHD programs and other HSPHD contracted providers and health care providers. **By signing below, I acknowledge that I received this form.**[1]

Signatures

Print Client Name

Client Signature

Date

Print Parent, Guardian or Personal Representative Name

Parent, Guardian or Personal Representative Signature

Date

☐ Client is a minor ☐ Client has a physical or mental disability ☐ Other _____

☐ The client was given the Notice of Privacy Practices

☐ The client was given the Information Disclosure Form

1. I understand that even if I do not sign this form, my information, including mental health data, is part of the department electronic record system and may be accessed without my permission for certain activities HSPHD is required to do by law (for example, Adult Protection Investigations, Child Protection Investigations, or Pre-Commitment Screenings).

INFORMATION DISCLOSURE NON-EPIC HSPHD CLIENTS

Authorization to Release Chemical Health Data (if applicable)

Federal law requires my consent to release any chemical health data, including the existence of that data, in my social services record. **By signing below in this section,** I authorize my case manager to release chemical health data about me, verbally or documents from my case record, to my other assigned workers for the purpose of coordinating the services that I receive from HSPHD. Also, if I am a Hennepin Health Member, I authorize my case manager to release chemical health data about me, verbally or documents from my case record, to the other Hennepin Health participating departments [2] for the purpose of coordinating the services that I receive from HSPHD and Hennepin Health.

I understand that:

- My case manager will release only the information necessary for the coordination of services.
- I may stop this consent at any time by telling my case manager or any of my other workers.
- HSPHD will not condition treatment or eligibility for benefits on whether I sign this consent.
- This consent is valid for one year unless I specify an earlier date here. Earlier Date _____

Signatures

Client Signature	Date
Parent, Guardian or Authorized Representative Signature	Date

☐ Client is a minor ☐ Client has a physical or mental disability ☐ Other _____

2. Hennepin Health Participating Departments include: Metropolitan Health Plan, NorthPoint Health and Wellness, Human Services and Public Health Department and Hennepin County Medical Center and its clinics.

SMI Person No.: