



Minnesota Disability Support Alternatives

110 10th Ave N Unit 10 | St. Cloud, MN 56301

Phone: 612-470-1585 | Fax: 1-651-560-5578 | main@mndsa.org | www.mndsa.org

AUTHORIZATION TO RELEASE INFORMATION

SECTION ONE

Name:	Previous Names:
Date of Birth:	PMI:
Address:	
Phone:	Email:

SECTION TWO

I am requesting information be released to, and exchanged with (verbal and written), **Minnesota Disability Support Alternatives** from the following:

FMS:	Case Manager/County:
Phone:	Phone:
Email:	Email:
State of Minnesota	
Other (Ex. Family/Friend):	

SECTION THREE

The following information is to be released:

- **All health-related information**, except for that related to chemical dependency program treatment and psychotherapy notes.
- Government information related to **Home and Community Based Waivers**, including assessments and related waiver documents.
- Insurance coverage information

SECTION FOUR

This release includes both written and oral information. By signing this form, you are giving the above permission to talk about the information described in this release.

SECTION FIVE

The purpose for releasing information is:

- **Coordination of services for the Consumer Directed Community Supports (CDCS)**
- **FMS Billing for Consumer Directed Community Supports (CDCS)**

SECTION SIX

I understand that by signing this form, I am requesting that the health and other relevant information specified in Section Three be sent to the third party, Minnesota Disability Support Alternatives. I may stop this consent at any time by writing to the facilities/organizations/individuals in Section Two. If they have already released the information based on my consent, my request to stop will not work for that information. **This consent will expire one year from the date the form is signed.**

Consumer Signature

OR Legally Authorized Representative:

Representative relationship to consumer:

Date Signed:



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Electronic Communication Authorization

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. government to protect your Personal Health Information (PHI). **Unencrypted email (standard email) and unencrypted text messaging (standard text messaging) does not protect your Personal Health Information.** Most email and text messaging are not encrypted, meaning that when you send, receive, or store information in your email or text messages it is not encrypted. This means that a third party could intercept (hack) email and text communications and access your Personal Health Information.

HIPAA allows reasonable accommodations to be made to ensure you have convenient access to your Personal Health Information. This means you have the right, if you have been made aware of and understand the risks, to receive unencrypted email, text communications, and electronic documents that contain Personal Health Information.

The following pages will give you options to customize your electronic communication with MNDSA. **If you choose to fill out the All Electronic Communication section regarding all electronic communication you will not need to fill out any additional sections.**

All Electronic Communication (Email, Text Messaging, Electronic Documents)

I understand the risks of unencrypted electronic communication and do hereby give permission to Minnesota Disability Support Alternatives to send me Personal Health Information via unencrypted electronic communication.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Email approved by Consumer/Legal Guardian (Example: xxx@gmail.com)

Text Messages approved by Consumer/Legal Guardian (Example: 651-317-4685)

- ☐ I understand the risks of unencrypted electronic communication and elect to have Minnesota Disability Support Alternatives send any Personal Health Information through encrypted electronic communication. I understand that once I download this information it will no longer be encrypted.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

This authorization is in effect until you tell us in writing to cancel it. If your email, text messaging number, or electronic document preferences change you must complete a new form.



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I do not wish to receive Personal Health Information via electronic communication. I understand that by selecting this option Minnesota Disability Support Alternatives will not be able to freely communicate with me via electronic communication and all documentation will have to be sent in hardcopy via mail.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Email (Please select one option.)

- ☐ I understand the risks of unencrypted email and do hereby give permission to Minnesota Disability Support Alternatives to send me Personal Health Information via unencrypted email.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Email approved by Consumer/Legal Guardian (Example: xxx@gmail.com)

- ☐ I understand the risks of unencrypted email and elect to have Minnesota Disability Support Alternatives send any Personal Health Information through encrypted email. I understand that once I download this information it will no longer be encrypted.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Email approved by Consumer/Legal Guardian (Example: xxx@gmail.com)

- ☐ I do not wish to receive Personal Health Information via email. I understand that by selecting this option Minnesota Disability Support Alternatives will not be able to freely communicate with me via email.

Date: _____

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

This authorization is in effect until you tell us in writing to cancel it. If your email, text messaging number, or electronic document preferences change you must complete a new form.



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Text Messaging (Please select one option.)

I understand the risks of unencrypted text messaging and do hereby give permission to Minnesota Disability Support Alternatives to send me Personal Health Information via unencrypted text messaging.

Date:

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Text Messages approved by Consumer/Legal Guardian (Example: 651-317-4685)

- ☐ I do not wish to receive Personal Health Information via text messaging. I understand that by selecting this option Minnesota Disability Support Alternatives will not be able to freely communicate with me via text messaging.

Date:

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

Electronic Documents (Please select one option.)

- ☐ I prefer to receive as many electronic documents as possible and do hereby give permission to Minnesota Disability Support Alternatives to send me documents electronically instead of providing me paper copies. If I would like to also receive a paper copy of any document, I will formally request the document be sent to me in hard copy (paper) on a document by document basis.

Date:

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

- ☐ I prefer to receive paper documents. I understand that by selecting this option Minnesota Disability Support Alternatives will provide all documents to me in paper format. If I would like to also receive an electronic copy of any document, I will formally request the document be sent to me electronically on a document by document basis.

Date:

Signature Consumer/Legal Guardian

Printed Name/Relationship to Consumer (if applicable)

This authorization is in effect until you tell us in writing to cancel it. If your email, text messaging number, or electronic document preferences change you must complete a new form.



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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Assist with educating you in increasing your self-advocacy skills

Our Uses and Disclosures

We may use and share your information as we:

- Help create, manage, and amend your CSP and HSP
- Run our organization
- Help with public health and safety issues
- Do internal research
- Comply with the law
- Address law enforcement and other government requests
- Respond to lawsuits and legal actions



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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your CSP and HSP

- You can ask to see or get a copy of any information we have about you. Ask us how to do this.
- We will provide a copy of your information, usually within 30 days of your request.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information in the course of attending this program.
- We are not required to agree to your request, and we may say “no” if it is an ethical or legal violation.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about payment and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.



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File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our HIPAA Compliance Officer:
Misha Liang, Director of Operations & Compliance.
Email: misha@mndsa.org Phone: 612-254-7277
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.



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Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Run our organization

- We can use and disclose your information to run our organization, do internal research, and contact you when necessary.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways related to court mandated reporting and fraud.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address law enforcement and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.



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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Additional Information

- All of our employees are court mandated reporters. We are required by law to report suspected child/vulnerable adult abuse and/or neglect.
- All of your files containing personal health information will be deleted and/or destroyed after 6 years if you are inactive with our agency.
- HIPAA Compliance Officer: Misha Liang, Director of Operations & Compliance
Email: misha@mndsa.org
Phone: 612-254-7277



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of

(Consumer/Legal Guardian/Responsible Party)

Disability Support Alternatives Notice of Privacy Practices.

Please Print Name

Consumer/Legal Guardian/Responsible Party Signature

Date

*Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Other (Please Specify)