DEPARTMENT OF HEALTH

Consent to Release Information to the Minnesota Department of Health
Refugee Health Program

PURPOSE

The Resettlement Agency (RA) or clinic may refer your case to the Minnesota Department of Health's Refugee Health Program. This referral will help connect you to specific health services in addition to your initial Refugee Health Assessment Exam if necessary.

I understand

☐ that I have the right to refuse to allow the sharing of my health information and that I will not be penalized for refusing. However, I understand that if I refuse, I may not be connected to some available services because of lack of information.

I also understand

☐ that I may cancel this consent any time before the information is released. This consent form expires two years after signing.

CONSENT

I understand that **my records** are protected under State and Federal privacy laws and cannot be disclosed without my written consent, unless otherwise provided by law.

☐ I hereby **give my permission** to my or my children/dependents' voluntary resettlement agency, health care provider(s), and the clinic(s) where I have received or will receive care to release and receive medical and health-related information to and from the Minnesota Department of Health Refugee Health Program in order to help arrange health services that are necessary to treat me or my dependent(s)' health condition(s).

I understand that this information will only be shared with people who will directly help me or my children/dependents access health care and resources or those who may need my or their information for services to help me.

☐ I hereby **give my permission** to the Minnesota Department of Health Refugee Health Program and the Minnesota Department of Human Services to share medical and health-related information with each other in order to help me or my children/dependent(s) to get the health care that I need and to improve health care services for refugees.

1._____ _____ _____

Printed Name of Client Signature Date

FILE Number: _____ A-number: _____

I give consent for my children/dependents listed below:

1. _____A#_____Parent/Guardian initials: _____
2. _____ A#_____Parent/Guardian initials: _____
3. _____ A#_____Parent/Guardian initials: _____
4. _____ A#_____Parent/Guardian initials: _____
5. _____ A#_____Parent/Guardian initials: _____

6. _____ A#_____Parent/Guardian initials: _____