PINE COUNTY SHERIFF'S OFFICE
SUITE 100
635 NORTHRIDGE DRIVE NW
PINE CITY, MN 55063
(320)-629-8380
Toll free 1-800-450-3930
Fax (320) 629-8392

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION

I hereby authorize _____
(Name and Address of Releasing Facility)

Through it's employees, representatives and other personnel possessing any and all information pertaining to:

NAME OF INDIVIDUAL _____

INDIVIDUAL'S DATE OF BIRTH:_____

To release any and all information they have to the Pine County Sheriff's Office at the above address.

RE: Medical Treatment on: **DATE(s)** _____

All information regarding Alcohol and/or Drug Abuse or Behavioral Health is requested **unless you restrict** by initialing below:

_____ Do not release Alcohol and/or Drug Abuse information
_____ Do not release Behavioral Health information

ACKNOWLEDGEMENT OF UNDERSTANDING:

* I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
* I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
* I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
* I understand that this medical facility may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
* I understand a photocopy or fax of this form is the same as the original.

The purpose of this disclosure is for legal/case investigation purposes. I hereby declare that I have read this authorization and have voluntarily signed it and acknowledge receipt of a copy.

Signed _____ Date _____
(Individual or Guardian of Individual)

Witness _____ Date _____

Deputy _____ ICR # _____