episcopal MIGRATION MINISTRIES

Case Number: _____

AUTHORIZATION TO RELEASE INFORMATION

Your Right to Privacy: You are being asked to sign a release of information that will allow agencies providing services to share information about you and your family.[i] This information will allow these agencies to serve you better by helping them coordinate services and work together toward common goals.
Your signature on this form is not required for treatment, payment, enrollment or eligibility for benefits. However, services requiring exchange of information with other providers may be limited without this specific authorization. You may revoke or cancel this authorization in writing at any time. You may also request that particular information be considered confidential. Your request will assure confidentiality of this particular information even if you have signed the release of information agreement. Your right to privacy is very important to all service providers. Only information that is essential to providing services will be shared with other agencies.

Client Information:	
Client Name:	**Date of Birth**
Case #:	**Arrival Date:**

By my signature below, I authorize the release of the following information and records relating to my eligibility and the eligibility of my minor dependents (list names)

Minor Dependents:	

Information and records:

- ☐ Psychiatric/Psychological/Mental Health Assessments, Diagnosis, Summaries, & Progress Reports
- ☐ Medical Information: Reports, History, Testing, Lab Work
- ☐ Medical Information related to HIV/AIDS or related illness
- ☐ Family History, Information, & Participation
- ☐ Admission & Discharge Summaries
- ☐ Chemical Dependency Assessments, Information, & Summaries
- ☐ Personal Identification
- ☐ Employment / Work Related Information
- ☐ Financial Information
- ☐ Educational Information, Transcripts, Current Grade Level, & Testing
- ☐ Progress Reports
- ☐ Referral Recommendations & Information
- ☐ Legal History
- ☐ Other _____

Case Number: _____

Service Providers:

*I hereby authorize **Integrated Refugee and Immigrant Services (IRIS)** to release information to /or receive information from the following agencies checked below:*

- ☐ Episcopal Migration Ministries
- ☐ US Department of State, Bureau of Population, Refugees, and Migration
- ☐ US Department of Health and Human Services, Office of Refugee Resettlement
- ☐ US Citizenship and Immigration Services
- ☐ US Social Security Administration
- ☐ State Office for Refugees
- ☐ English Language Schools/ Training Centers
- ☐ Health Screening Provider
- ☐ Health Department
- ☐ Local Department of Social Services
- ☐ School
- ☐ Vocational Rehabilitation Services
- ☐ Employer/Work Verification

- ☐ **IRIS Co-Sponsor Group (Name)** _____
- ☐ Other (specify) _____
- ☐ Other Local Resettlement Agency _____
- ☐ Other Local Resettlement Agency _____

I authorize the sharing of this information for the limited purposes of determining eligibility for services and assistance, coordinating care, and meeting the goals of my family self-sufficiency plan. I understand that this information may be shared by phone, fax, scan, mail, e-mail or in person.

Additional special instructions:

I understand that a copy of the completed and signed authorization form will be made available to me at my request. This authorization remains in effect until one (1) year from the date indicated below. I understand that I may revoke this authorization in writing at any time by submitting a written statement of revocation to the originating office listed above. A copy of this authorization is as valid as the original.

	Print Name	***Signature***	***Date***
Client*			
Parent, Guardian, Custodian for (M2-M6) _____ *(if applicable, print client name)*			
Interpreter			
Co-Sponsor Group (Co-)Chair			

*A separate Authorization to Release Information form should be completed for each adult client.

[i] This request is made pursuant to the authority granted by the cooperative agreement between the Domestic and Foreign Missionary Society (DFMS) and the US Department of State, Bureau of Population, Refugees, and Migration and, as applicable, between DFMS and the US Department of Health and Human Services, Office of Refugee Resettlement.