

# NEW BEGINNINGS

40 North 25<sup>th</sup> Avenue  
St. Cloud, MN 56303  
(320) 255-1252  
(320) 255-1253 FAX

## AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, \_\_\_\_\_, D.O.B.: \_\_\_\_\_,

Authorize the following checked and initialed businesses, organizations, and individuals to release and/or exchange information with New Beginnings for the purpose of determining financial eligibility, assessment, evaluation, treatment planning, referral assistance, case management, and determining eligibility for shelter and services:

- |   |  |
|---|--|
| <input type="checkbox"/> Stearns County Human Services ____       | <input type="checkbox"/> St. Cloud District 742 Schools ____     |
| <input type="checkbox"/> Stearns County WIC ____                  | <input type="checkbox"/> Work Force Center ____                  |
| <input type="checkbox"/> Stearns County Public Health Nurse ____  | <input type="checkbox"/> Stearns/Benton Employment Training ____ |
| <input type="checkbox"/> Stearns County Probation Department ____ | <input type="checkbox"/> Early Head Start ____                   |
| <input type="checkbox"/> _____ County Human Services ____         | <input type="checkbox"/> Birthline ____                          |
| <input type="checkbox"/> _____ Daycare ____                       | <input type="checkbox"/> Teen Moms ____                          |
| <input type="checkbox"/> _____ Mentor ____                        | <input type="checkbox"/> _____ Other ____                        |
| <input type="checkbox"/> _____ School ____                        | <input type="checkbox"/> _____ Other ____                        |
| <input type="checkbox"/> Crisis Nursery ____                      | <input type="checkbox"/> _____ Other ____                        |

I understand that I may refuse to sign this authorization. I understand that the refusal may affect my eligibility for assistance and/or services from New Beginnings.

I understand that I may revoke this consent at any time. I understand that this consent expires upon the fulfillment of the above stated purpose(s), 30 days after leaving New Beginnings, or 18 months after the date of my signature, whichever occurs first.

Signature of Client/Potential Client:	Date:
Signature of Responsible Party for Minor or Incompetent Person:	New Beginnings Representative:

A fax or photocopy of this Authorization to Release Information shall be valid as though it was an original.  
3 /2009

