



Bois Forte Tribal Court Probation Department

12907 PALMQUIST ROAD, SUITE B
ORR, MN 55771
PHONE: 218-757-3462 | FAX: 218-757-0064

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Please print clearly

TODAY'S DATE: _____

Name: _____ DOB: _____

Address: _____

I (print your name) _____, the undersigned, hereby authorize the **Bois Forte Probation Department** (12907 Palmquist Road Suite B, Orr, MN 55771) or its authorized representative(s), bearing this release or copy of this release to:

RELEASE TO: RELEASE FROM: EXCHANGE WITH:

Agency/Individual: _____

Address: _____

Phone/Email: _____

I AUTHORIZE THE RELEASE OR DISCLOSURE OF THE FOLLOWING INFORMATION:

- Comprehensive Assessment- Rule 25 Summary and Recommendations
- Diagnostic Assessment and Recommendations
- Psychological and Psychiatric Evaluation and Recommendations
- DVI assessment and recommendations
- Dates of Treatment (timeframe) _____
- Discharge Plan/ Completion Letter
- Appointment Attendance Report
- Employment Records History
- Treatment Progress Reports
- Financial History
- Community Service Verification
- Probation Records
- Other: _____

FOR THE PURPOSE OF:

The purpose of and need for the disclosure is to inform the Bois Forte Probation or agency(ies) or individuals listed above of attendance and progress or coordinate services.

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of release from confinement, probation, or other proceedings under which I was mandated into required services.
- This authorization will expire at the end of my probation term.
- I further understand that that certain information pertaining to my participate and progress in Court ordered programs may be used for the purposes of evaluations and/or audit, and verification.
- I understand that any disclosure made between the above-named agencies or individuals may re-disclose any confidential information regarding any of my mental health or drugs and alcohol abuse records to those in connection with official court duties.
- I understand why I am being asked to authorize the release of information.
- I understand a photocopy or fax of this form is the same as the original.

Signature of Individual Authorizing Release Date

Signature of Witness (as needed) Date

Relationship to Client:

- Self
- Parent of Minor
- Guardian/Conservator