SEXUAL ASSAULT PROGRAM
of northern st. louis county

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: _____

Parent/Guardian: _____

Address: _____

Phone: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

I hereby authorize the Sexual Assault Program staff to exchange information pertinent to the above-named individual for the purpose of continuing care and Program involvement for services provided during the period of one year from date signed with:

___ SLC Social Services Department _____

___ Mental Health _____

___ Law Enforcement _____

___ County Attorney's Office/Staff _____

___ Other (Please Specify): _____

Revocation and Expiration of Consent:
Upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation unless otherwise specified one year from date signed. I understand that I may revoke this consent to release information at any time by written notice, except when legal action prevents revocation (probation parole court confinement). However, any release made in good faith, prior to receipt of revocation, shall be deemed valid. I also understand this that information disclosed by this consent cannot be released to anyone else other than those listed above unless I give written permission.

_____ Client's Signature

_____ Staff Signature

_____ Parent/Guardian's Signature

_____ Date

327 1st St. S. Suite 17, Virginia, MN 55792
218-749-4725 218-780-7227 800-300-3102