

## CONSENT FOR RELEASE OF INFORMATION OR IDENTITY

### I consent to the release of the following information:

1. Who has the information? *Park Towers Management Office or the Tenant Services Coordinator.*
2. What information will be released? *Name and/or Personal Data*
3. Who will the information be given to? *The information may be given to the following agencies or persons: McLeod County Social Services, McLeod County Public Health Nursing, Area Mental Health Agency, Hutchinson Hospital, Clinic and Day Care Providers, Family Members, ConnectCare and Tri-Star.*
4. WHY? *To obtain help when needed or to resolve problems as they arise.*

**I have been told what will happen if this information is or is not released. I have been told of my right to refuse to release this information and what will happen if I refuse.**

**The information to be released is private and will not be released without my consent or unless the law provides for the release of the information.**

**I understand that I may revoke this consent upon written notice unless the information has already been released. My consent will automatically expire 1 year from the date of my signature, or when the activities I have authorized the tenant service coordinator to perform are complete, whichever comes first.**

\_\_\_\_\_  
Signature of Tenant or Representative:

\_\_\_\_\_  
Date:

If tenant unable to sign, reason tenant unable to sign \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_