



Minnesota Service C.O.R.E.
AUTHORIZATION TO DISCLOSE
Protected Veteran Information



I, _____, _____ hereby authorize Lutheran
Printed Name of Veteran Date of Birth

Social Service of Minnesota (LSS) Behavioral Health / Financial Counseling to release data

about me to the MN Department of Veterans Affairs and _____,
Name of CVSO

of _____ County, _____
Name of County Address City, State, Zip Code

as described on this form.

- 1. I understand that I have asked LSS Behavioral Health / Financial Counseling to release the data.
2. The specific data I want LSS Behavioral Health / Financial Counseling to release is:
3. I understand that although the data are classified as private at LSS Behavioral Health / Financial Counseling the classification/treatment of the data at
Name of County depends on laws or policies of that county.
4. Explanation of your Rights: If you have a question about anything on this form, or would like more explanation, please talk with your CVSO.

Acknowledged and agreed to by the individual to whom the Protected Information pertains:

Veteran's Signature: _____

Veteran's Name (printed): _____

Date: _____

Acknowledged and agreed to by the individual's representative who is empowered to act on his/her behalf by reason of: _____

Representative Signature: _____

Representative Name (printed): _____

Date: _____

This Authorization expires one year from signature date or upon closure of file, whichever occurs first.