Authorization — Consent to Release Information

This is a(n) ☐ Initial Request ☐ Modified Request ☐ Revocation/Withdrawal of Prior Request Date of Prior Request (if applicable): / /

Agency Requesting Information:

Agency Name	Contact Name/Title		
Mailing Address			
City		State	Zip
Email	Phone	Fax	Date

Client Information:

Last Name	First Name	MI	Date of Birth
Physical Address			
City	State	Zip	Email:
Permanent Address (If different than physical address)			
City	State	Zip	Email:
Type of Identifier: ☐ SSN ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #:	Role:	

Consenter/Person Authorizing Consent (if person above is a minor)

Last Name	First Name	MI	Date of Birth
Physical Address			
City	State	Zip	Email:
Permanent Address (If different than physical address)			
City	State	Zip	Email:
Type of Identifier: ☐ SSN ☐ School ID ☐ DL ☐ State ID ☐ Child Welfare Case # ☐ Case Report # ☐ JD# ☐ Passport	Identifier #:	Role:	

To Release Information From:

Agency Name	Name/Title		
Mailing Address			
City	State	Zip	Email:

To Release Information To:

Agency Name	Name/Title		
Mailing Address			
City	State	Zip	Email:

For the Purpose of:

☐ Adjudication ☐ Coordination of Services ☐ Insurance (Health/Life) ☐ Placement ☐ Treatment
☐ Assessment ☐ Intake ☐ Interdisciplinary Team Staffing ☐ Pretrial
☐ Other:_____

Type of Records/Information Requested:

Education
☐ School Grades
☐ School Attendance Records
☐ School Behavior Reports
☐ IEP's/504
☐ Other:_____

Justice
☐ Probation History
☐ Programs
☐ Pre-Trial Services
☐ Other Court Records
☐ Correction
☐ Parole
☐ Detention (if juvenile)
☐ Other:_____

Human Service Records
☐ Human Service Records
☐ Child Welfare History
☐ Other:_____

Benefit Programs
_____
_____

Other
_____
_____
_____
_____
_____

Preparer's Intitials _____ **Consenter's Intitials** _____

Substance Abuse/Medical/Mental Health Records Request:

[Check box for records being requested. Client must initial **after** each category that is applicable to this request]

- ☐ Name/Personal Identifying Information (PII):_____
- ☐ Patient Status in treatment:_____
  - ☐ Outpatient ☐ Inpatient
- ☐ Evaluations (initial and subsequent) :_____
- ☐ Mental Health Intake
- ☐ Mental Health Screen
- ☐ Summaries of alcohol/drug and mental health assessment results/history:_____
- ☐ Summaries of mental health service plans, progress and compliance:_____
- ☐ Attendance in alcohol/drug treatment and mental discharge plan(s) for alcohol/ drug treatment and mental health services, discharge status:_____
- ☐ Other:_____ Code:_____
  Diagnosis: _____ Code:_____

Date of Service/Injury/Court Event: | **Date of Diagnosis Event or Condition:**

Expiration of Consent: ☐ Expiration of Event ☐ One Year from Date of Event ☐ Date: (MM/DD/YYYY)

How is this infomation being released? ☐ Fax ☐ Email ☐ Telephone ☐ In Person ☐ Other

This information is being used for the purpose of:

Signature of person authorizing consent: Date: / /

Type or print name:

Signature of youth: Date: / /

Type or print name:

☐ By my signature, I consent to the release of information contained on this form for use by the requesting agency(cies), and I understand that any agency or individual using the confidential information or records obtained will take all necessary steps to protect the confidentiality of the above named juvenile/child's identity. I acknowledge that I have been informed of my rights to refuse to sign this form, and any conditions related to my consent or refusal, and that I am entitled to receive a copy of the signed form.

☐ Consenter declined release of information. _____[staff initial] [Copy Provided to Client]
Date Declined: (MM/DD/YYYY)_____

☐ **Liability/Hold Harmless Statement:** *(Check Only If Applicable to Request)*
I understand that information disclosed to non-HIPAA entities in accordance with this release/ authorization may be re-disclosed by the recipient and, in such cases; the information may no longer be protected by the HIPAA Privacy Regulations.

Mandatory Disclosure Limitation – Substance Abuse 42 CFR Part 2:
When programs operating under Part 2 disclose information pursuant to a consent form, the following statement is required regarding re-disclosure. 42 CFR §2.32: *This information has been disclosed to you from records whose confidentiality is protected by Federal law as well as the Health Insurance Portability and Accountability Act (HIPAA). Federal Regulations (42 CFR Part 2) prohibit you from **making any further disclosure of it without the specific written consent of person to whom it pertains,** or as otherwise permitted by such regulations: a general authorization for the release of medical or other information is NOT sufficient for this purpose.*

Notice of Law: You must be advised of the federal laws and regulations which protect the records contained in this consent and provided with a notice of the (AGENCY) ' privacy practices and bill of rights" under the Federal Privacy Rule which relate to the requested records. Constitutional Right to Privacy 45 CFR 164.502(g)(3)(ii) for Notice to Parent

Confidentiality Notice for Electronic Transmittal: This release, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential information. If you have received this communication in error, please immediately notify the sender. In addition, if you have received this in error, do not review, distribute, or copy the document or attachments.

Consent Expiration: This authorization expires no later than (ONE YEAR) or (Number of DAYS/ DATE) from the date of signature, or upon the completion services defined, whichever is less. Length of time consent is valid can be less than a year, as defined by program or provider, or set by length of program/ referral, period of time that records are utilized for specified consent purpose. (CFR §164.520(b)). Educational Programs must keep a copy of each signed form for six (6) years from its expiration date, FERPA 34 CFR 99.32. See agency specific time frames for record retention.

Consent Period: This release shall remain in effect until such time as I provide the (AGENCY) with a written or oral notification to revoke. Exceptions do not cover data that was previously released for specific treatment or referral.

Non-consensual Release of Confidential Treatment Data: Under Federal Confidentiality Regulations, no information about the juvenile's participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order.

Notice To Receiving AGENCY: This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal Law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains. (See: 42 CFR § 2.4. A violation of Section 290dd-2 or the accompanying regulations is a crime, for which the violator can be fined up to $500 for a first offense and up to $5,000 for subsequent offenses. Also, the program where the violation occurred can lose its federal funding, and both the program and violator can lose their licenses under state law.)

Redisclosure Notice to Receiving Agencies: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL LAW PROHIBITS YOU FROM MAKING FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. IF APPLICABLE, A MINIMUM NECESSARY DETERMINATION HAS BEEN APPLIED TO THIS RELEASE/ AUTHORIZATION. IF YOU HAVE QUESTIONS CONCERNING THIS RELEASE PLEASE CALL (PROVIDER AGENCY PHONE #) OR PLEASE SEND INFORMATION TO: (PROVIDER AGENCY NAME AND ADDRESS AND FAX)

Revocation Limitation: This release/authorization may be revoked at any time by written notice to AGENCY, except to the extent that action has already been taken to comply with it. Without such revocation, this release/ authorization will expire on (specific date) or if left blank, one year from the date signed, or if included as part of a Court Order or condition of probation, upon the terms specified. Consenter may revoke consent in writing by contacting the releasing agency. This revocation will be recorded in the AGENCY record. The Privacy Rule requires written revocation of an authorization to release HIPAA information (45 CFR §164.508(b)(5)). Both Part 2 and the Privacy Rule allow the program to make a disclosure for services already rendered in reliance on a signed consent or authorization form. See 42 CFR §2.31(a)(8) and 45 CFR §164.508(b)(5)(i).

Treatment Data Disclosure Limitation: Under Federal Confidentiality Regulations, no information about NAMED child's participation in treatment can be disclosed without written consent except in the case of medical emergency, child abuse or Court Order. A substance abuse treatment program is defined as an individual or entity that provides alcohol or drug abuse diagnosis, treatment or referral. In this document, the term "program" includes both individual substance abuse providers and substance abuse provider organizations. Written/ Verbal Consent: This consent must be in writing to be valid, unless consent is for Substance Abuse Treatment – when verbal consent is acceptable. Verbal consent may also be accepted in specific emergency situations. See participatinig agency's policy and statutes.

Parental/ Guardian Right to inspect/ access Medical/ MH records: When child covered by this consent is under 18, the parent/ guardian has the right to view, and/or have received photocopies of the medical records of AGENCY/MH FACILITY NAME inpatient treatment and amend the named minor child's medical record, except in abuse and neglect situations.

Preparer's Intitials | **Consenter's Intitials**