Authorization For Release of Information

Youth's Name

____

Parent/Legal Guardian Name

____

I____, parent/s or legal guardian/s of__________________________________, authorize information to be exchanged about me and the above named child between the following agencies or programs as listed below (*initial and/or fill in the blanks in all that apply*):

____ Mind Springs
____ JD/Truancy/D&N Court in the ___Judicial District
____ Division of Youth Corrections
____ FACET Team
____ Faith Partners
____ Garfield County Dept. of Human Services
____ Garfield County Public Health
____ Physician/Clinic/Hospital________________________
____ Counselor____________________________________
____ Ninth Judicial District Probation Department
____ School District/s______________________________
____ Screen Works
____ YouthZone
____ *Division of Criminal Justice state research team*(grant)*
____ Other (specify) _______________________________

Information to be used or disclosed

____ Mental health information *(requires youth signature age 15 and over)*
____ Assessment/diagnosis
____ Legal Information
____ Social history, background
____ Education history
____ Evaluation/testing results
____ Medical/lab information
____ Substance abuse information *(requires youth signature)*
____ HIV/AIDS information
____ Medication assessments, records
____ Updates, discharge summary
____ *Demographic and legal information *(DCJ grant)*
____ Other (specify) _______________________________

The disclosed information will be used for the following

____ At the request of the client
____ Multi-agency coordination of care
____ Treatment, payment or healthcare operations
____ Continuity of care
____ Obtaining services for the client
____ Evaluation purposes
____ Reports to courts or other agencies
____ *Division of Criminal Justice state evaluation *(grant)*
____ Other (specify) _______________________________

I understand that information released may be in written, verbal or electronic form and may include date (s) of contact, locations and reasons for contact, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, tests performed, and/or diagnosis. I understand that released information may include psychological/psychiatric, medical, shelter, case management, alcoholism, and drug and/or alcohol abuse information.

I understand that the purpose of this release of information is to allow the individuals/agencies chosen in the section above to access and use the information to establish and maintain continued care, better assess the effectiveness of the program, and/or to improve their services based on evaluation studies.

There is no guarantee that recipients of the information disclosed through this authorization will not re-disclose to another party.

Except in situations legally required or permitted, information about me cannot be disclosed to persons outside YouthZone without my written permission.

I understand that I may cancel this authorization at any time by giving written notice to the agencies or programs selected above. I understand that information exchanged prior to cancellation is excepted. Unless cancelled, this release of information will expire on ____/____/____ OR (if left blank) one year from my signature date OR in the event of:

____.

______________________________ Parent Signature Date	______________________________ Youth Signature Date *(Required for substance abuse at any age and mental health information age 15 and over)*	______________________________ Witness Signature Date
______________________________ Parent Signature Date		*[*required for DCJ grant]* Revised 10/15