

*YOUTH DYNAMICS, INC.*

**AUTHORIZATION TO RECEIVE / RELEASE INFORMATION**

I am the parent / guardian for the minor child, \_\_\_\_\_, DOB: \_\_\_\_\_.

As required by the Health Insurance Portability and Accountability Act of 1996 Youth Dynamics Inc. may not use or disclose this minor child's health information except as described in the Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for Youth Dynamics, Inc. to disclose only that information generated by Youth Dynamics, Inc., regarding the minor child named herein with the entities listed. You are also giving Youth Dynamics Inc. permission for entities listed below to release information to Youth Dynamics, Inc. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office. However, please understand that your revocation may come after disclosures have been made relying on your initial consent.

**I give permission for \_\_\_\_\_ to \_\_\_ release information to and/or \_\_\_ receive information from Youth Dynamics, Inc.:**

**Purpose(s) for which disclosure is authorized:**

<input type="checkbox"/> Determine / Maintain Clinical Eligibility	<input type="checkbox"/> Assess Needs of Client	<input type="checkbox"/> Coordinate & Monitor Education Services
<input type="checkbox"/> Determine / Maintain Financial Eligibility	<input type="checkbox"/> Treatment & Discharge Planning	<input type="checkbox"/> Coordinate & Monitor Medical Care
<input type="checkbox"/> Diagnosis & Evaluation	<input type="checkbox"/> Advocacy	<input type="checkbox"/> Other: Must Specify:

**The only records to be exchanged are:**

<input type="checkbox"/> Intake History / Admission Information	<input type="checkbox"/> Progress Notes / Reports	<input type="checkbox"/> Care Plans
<input type="checkbox"/> Clinical Assessments	<input type="checkbox"/> Chemical Dependency Assessment/ Summary	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Psychological Testing & Reports	<input type="checkbox"/> Regular/Special Education Records including CST & IEP	<input type="checkbox"/> Court Orders, SSN, Birth Certificates, & Tribal Enrollment
<input type="checkbox"/> Psycho-Educational Report	<input type="checkbox"/> Social Information / History	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psycho-Sexual Evaluation Report	<input type="checkbox"/> Medical Information	<input type="checkbox"/> Other: Must Specify:

If not revoked, this Release is valid for a period of 2 years (24 months) from the date it is signed or until all YDI services are terminated. This Release is subject to revocation at any time except to the extent that Youth Dynamics has already acted in reliance on it. The revocation is effective from the time it is communicated to Youth Dynamics, Inc.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Parent / Guardian Printed Name

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Witness Signature

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, except for the information protected by CFR 42 U.S.C. Sec 290dd-2 for alcohol/drug abuse records. Revocation: I hereby revoke the foregoing Consent.**

\_\_\_\_\_  
Parent / Guardian Printed Name

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Witness Signature

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

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