YOUTH DYNAMICS
AUTHORIZATION TO RECEIVE / RELEASE INFORMATION

I am the parent / guardian for the minor youth, _____ , DOB: _____ . As required by the Health Insurance Portability and Accountability Act of 1996 and CFR 42 U.S.C.Sec 290dd (Substance Abuse Records), Youth Dynamics 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 to disclose only that information generated by Youth Dynamics, regarding the minor child named herein with the entities listed. You are also giving Youth Dynamics permission for entities listed below to release information to Youth Dynamics. 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:

Purpose(s) for which disclosure is authorized:

❑ Determine / Maintain Clinical Eligibility	❑ Assess Needs of Youth	❑ Coordinate & Monitor Education Services
❑ Determine / Maintain Financial Eligibility	❑ Treatment & Discharge Planning	❑ Coordinate & Monitor Medical Care
❑ Diagnosis & Evaluation	❑ Advocacy	❑ Other: Must Specify:

The only records to be exchanged are:

❑ Intake History / Admission Information	❑ Progress Notes / Reports	❑ Care Plans
❑ Clinical Assessments	❑ Chemical Dependency Assessment/ Summary	❑ Treatment Plans
❑ Psychological Testing & Reports	❑ Regular/Special Education Records including CST & IEP	❑ Court Orders, SSN, Birth Certificates, & Tribal Enrollment
❑ Psycho-Educational Report	❑ Social Information / History	❑ Discharge Summary
❑ Psycho-Sexual Evaluation Report	❑ Medical Information	❑ 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. I understand that I am under no obligation to sign this authorization. I further understand that my child's ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed with this authorization. I understand that Youth Dynamics may receive compensation for the uses and disclosures that I have authorized.

Dated this _____ day of _____, 20___.

_____	_____
Parent / Guardian Printed Name	Youth/Witness Printed Name
_____	_____
Parent / Guardian Signature	Youth/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 for substance abuse records.

REVOCATION: DO NOT SIGN HERE UNLESS REVOKING CONSENT TO RELEASE OR RECEIVE INFORMATION:

I hereby revoke the foregoing Consent.

_____	_____
Parent / Guardian Printed Name	Youth/Witness Printed Name
_____	_____
Parent / Guardian Signature	Youth/Witness Signature
Date: _____	Date: _____