Youth Dynamics

AUTHORIZATION TO RECEIVE / RELEASE INFORMATION

Youth Name:_____ **DOB:** ____/____/____

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	❑ Substance Use Assessment	❑ 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:

By signing this authorization form, I understand and agree with the following:

- As required by HIPAA and CFR 42 U.S.C. Sec 290dd (Substance Use Records) Youth Dynamics does not use or disclose this minor child's health information except as described in the Notice of Privacy Practices.
- I give permission for Youth Dynamics to disclose YDI generated and collateral information with the entity listed.
- I give permission for the entity listed to release information to Youth Dynamics.
- I have the right to revoke this authorization at any time by signing and dating the revocation section. Revocation will not apply to information already disclosed in response to this authorization.
- This information in the minor youth's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral & mental health services, and treatment for alcohol and drug abuse.
- This authorization does not apply to psychotherapy notes.
- The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected by 45 CFR 164.508, except for the information protected by CFR 42 U.S.C. Sec 290dd for Substance Use records.
- I have the right to inspect and obtain a copy of information disclosed with this authorization.
- Unless otherwise revoked, this authorization will expire 2 years (24 months) from the date it is signed or until all Youth Dynamics services are terminated.

Dated this _____ **day of** _____ **, 20**_____**.**

Parent / Guardian Printed Name	Youth/Witness Printed Name
Parent / Guardian Signature	Youth/Witness Signature
Address:	Address:
Phone:	Phone:

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