

**Region II Human Services
Authorization for Release of Information
Youth Care Coordination**

I, _____ date of birth _____
[patient's name]

Authorize _____
[name or general designation of individual or entity making the disclosure]

to disclose the following information:

- | | | |
|---|---|---|
| <input type="checkbox"/> Urgent Outpatient Report | <input type="checkbox"/> Periodic Summaries of treatment progress | <input type="checkbox"/> Initial Diagnostic Interview |
| <input type="checkbox"/> Substance Abuse Eval | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Current Medication List | <input type="checkbox"/> Med Check notes |
| <input type="checkbox"/> Safety Plan | <input type="checkbox"/> Attendance and participation | <input type="checkbox"/> Education records |
| <input type="checkbox"/> Other | | |

any disclosures selected above may include information pertaining to substance use disorder records

To: _____
(name of individuals and/or entity receiving information)

The purpose of the disclosure is _____
[describe the purpose of the disclosure; as specific as possible]

I understand that my substance use disorder records are protected under the Federal regulations governing Confidential and Substance US Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time by sending a letter to the Privacy Officer of the organization disclosing my information, except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

I understand that I may inspect and have a copy of the health information described in this authorization.

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

I have been provided a copy of this form.

Dated: _____

Signature of Client

Signature of Personal Representative

Describe authority to sign on behalf of client

Signature of Witness