Authorization for Disclosure of Confidential Information

I, _____, whose Date of Birth is _____

authorize the _____ (title) for the _____ County Juvenile Court to disclose to and/or obtain from the individual and/or agency named below the following information:

_____

[Insert Name of Person or Title of Person or Organization]

Furthermore, I understand that my alcohol and/or drug treatment records are protected under the Federal Regulations governing Confidentiality and Drug Abuse 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.

Information to be Disclosed/Obtained

(Initial each item to be disclosed)

_____ Intake
_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Treatment Plan or Summary
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Substance Use Testing
_____ Continuing Care Plan
_____ Discharge/Transfer Summary
_____Other_____

Purpose

The information may be used or disclosed in connection with a mental health/substance use evaluation or on-going participation in **PATHS**, a Family Treatment Court. If otherwise, please specify:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification, via USPS, etc. to this Juvenile Court

I further understand that a revocation of this authorization shall not apply to any action taken in reliance to this authorization.

Conditions

I further understand that the Juvenile Court will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure

Unless requested in writing that the disclosure be made in a certain format, the information disclosed as permitted by this authorization will be in any manner deemed appropriate and consistent with applicable law, including, but not limited to verbally, in paper format, or electronically.

Redisclosure

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires 90 days from the date that it is signed or upon discharge from the program.

In addition, my records are protected by the HIPAA privacy regulations, and all applicable State laws.

I acknowledge receiving a copy of this authorization.

_____ _____

Signature Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____

Witness Date