Authorization for Release of Information for Youth

Child's Name: ______________________________________ **DOB:** ________________ **MRN:** *if known*__________________

I hereby authorize Anazao Community Partners
Write/Check all that apply:

To provide to:					the following minimum necessary information:
	All Records		Other: (Specify which documents to release)		
	Most Recent Admission		All Treatment Episodes		Other: (Specify)

I understand that this authorization is voluntary and the information, which I have the right to inspect at ACP, will be used for the following purpose(s) and no other: *Write/Check all that apply:*

	Continuity of Care		To Coordinate Treatment		To Obtain Assessment Information
	Other: (Specify)				

Information to be released in: *Check all that apply*

	All		Letter/Copy		Fax		Email		Text		Verbal

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3). Your refusal to consent will mean that the information will not be requested or released. I understand that my child's care and payment for my child's care will not be affected if I do not sign however, this may hamper your child's further evaluation and treatment. If no date, event or condition upon which the consent will expire is noted this consent will expire 90 days from the signing of the release.

Check One:				*Check Event of Expiration:*			
	Grant Consent		Refuse Consent		Discharge		Other: (Specify)

Revocation: Authorization may be revoked at any time except when already been acted upon. I hereby revoke consent.		
Date of Revocation:	Signature of Client or Parent/Guardian:	Witness Signature:

Notice regarding non-residential parents: a non-residential parent is entitled to access to any record that is related to the child unless the court determines and issues an order that it would not be in the best interest of the child for the non-residential parent to have access to the records. (See ORC 3109.051 H1,2,3)

Prohibition against redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules. Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) Redisclosure must be consented to in writing by the person who consented to this disclosure.

Signature of Client: *(if 12 or older)* ____ Date: _______________

Guardian: *(if Client under 18)* ____ Date: _______________

Witness: ____ Date: _______________

For questions about this form, or assistance completing the form, please call our office at 1-800-721-9472.