Authorization for Release of Protected Health Information

Youth's Name: _____ **Date of Birth:** _____

Person / Organization providing the information:	**Person / Organization receiving the information:**
_____	_____
_____	_____
_____	_____
_____	_____

I specifically authorize the disclosure of the following protected health information:

_____

_____

_____

_____

Reason for the release of information: ☐ Individual's request ☐ Legal matter
☐ Other: (please specify) _____

When will this authorization expire? ☐ 90 days ☐ One year
☐ Other expiration date: _____

_____ *initial* I, or my parent/legal guardian, authorize the disclosure of my protected health information as I have described in this form.

_____ *initial* I understand that I can refuse to sign this authorization, and that I do not have to allow the release of my protected health information. I understand that my health care will not be affected if I refuse to sign this form.

_____ *initial* I know that I can change my mind, and that I can revoke this authorization in writing at any time by sending a signed and dated written statement to the Department of Juvenile Justice Office of Legal Services.

_____ *initial* I understand that my protected health information could be disclosed again and no longer protected by federal health information privacy regulations if the recipient(s) indicated above are not required by law to protect the privacy of the information.

_____ *initial* I understand that a photocopy of this form will be as valid as the original.

_____ *initial* I understand that I have the right to receive a copy of this form after I have signed it.

_____ *initial* I have had the opportunity to read and consider the content of this authorization. I confirm that the contents are consistent with my direction.

_____ *initial* I understand that my HIV-related information, STD-related information, family planning information, substance abuse treatment information, and psychotherapy notes will not be released, even to my parent/guardian, without my signature.

_____ _____

Youth's Signature (required for all releases) Date

Parent/Legal Guardian's Signature Date
(required if youth is under 18 years old)
(not required for HIV, STD, family planning, substance abuse, and psychotherapy notes)

_____ _____

Witness Signature Date

Parent/Legal Guardian's Printed Name Relationship

USE THIS SPACE ONLY TO WITHDRAW CONSENT

_____ _____ _____

Signature of Youth or Parent/Guardian Date **Print Name and Relationship** **Date Consent is Revoked**

Protected health information is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or, 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual.