Youth VILLAGES
The force for families

Authorization for the Release of Protected Information

Youth's Name: _____ DOB: _____ SSN: _____

I hereby authorize the staff of Youth Villages to:

_____ Discuss with _____ Send to _____ Receive information from

_____

(Name, Address, Phone Number and Email Address)

For the specific purpose of: _____

Authorization Type (*required*): One Time Only_____ Routine_____

Information to be released:

____Medical Evaluation/History/Physical
____Psychiatric Evaluation
____Social History
____Psychological
____Discharge Summary
____Educational/Special Ed Records
____Court Records
____Progress Notes/Admission Summary
____Other

____Statement from Therapist or Physician
____Physician's Orders/Notes
____Nurse's Notes
____Master Treatment Plan
____Treatment Plan Reviews
____Laboratory Test Results
____Audio Visual Recordings
____Substance Use Disorder

This authorization will remain in effect for 90 days following the date of signature for a one-time only release or for one year following the date of signature for a routine release. I understand that I have a right to revoke this authorization at any time, but if I do choose to revoke I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization or my insurance company (if applicable) when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign. I need not sign in order to assure treatment. I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable diseases. It may also include information about behavioral or mental health service, and referral and/or treatment for alcohol and drug abuse records, substance use disorder (means a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal) protected by Federal Confidentiality Rules 42 C.F.R. Part 2, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice. I understand that I may inspect/copy information to be used or disclosed, as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Clinical Information Systems Department at 901-251-5000.

_____ _____

Signature of Youth (*if at least 15 years of age or older where required*) Date

_____ _____ _____

Parent/Legally Authorized Representative Relationship to Youth Date

_____ _____

Signature of Witness Date