PICKAWAY COUNTY
TEAM (Together Everyone Achieves More) for YOUTH

AUTHORIZATION FOR RELEASE OF INFORMATION

Youth's Name ____________________________ Date of Birth ___________________

Section A: To be completed for all authorizations

The agencies and organizations checked below have my authorization to exchange information, both written and oral, regarding service delivery planning for the purpose of coordination and providing services for the above named person. I hereby authorize the use of disclosure of my individually identifiable health information or personal information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal Privacy Regulations. I understand I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Person/Organization providing the information:	Person/Organization receiving the information:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Specific description of the information, including date (s):
____
____
____
____

Information regarding the following will not be released unless initialed below:
_______Social Security Number
_______HIV or Aids related diagnosis and treatment
_______Substance abuse diagnosis and treatment

Section B: To be completed if a health care provider or health plan has requested authorization

1. The health care provider or health plan must complete the following:
   a. What is the purpose of the use or disclosure? ______________________________
   ____
   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_____ No_____

2. The youth or the youth's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. INITIALS: ___________
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. INITIALS: __________

Section C: To be completed for all authorizations

The youth or the youth's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/___ (DD/MM/YR) INITIALS: _______

2. I understand that I may revoke this authorization at any time by notifying the providing organization, in writing, but it won't have an affect on any actions taken prior to receiving the revocation. INITIALS _______

This form must be **complete** before signing.

____ ______________________

Signature of Youth or Youth's Representative Date

Printed Name of Youth's Representative: ____

Relationship to Youth: ____

Witness ____

Section D: Contact information

It is best to contact me by: Phone # ____

Mail: Address ____

____

Email Address: ____

The information has been disclosed to you from records protected by federal/sate confidentiality rules. Any further release of information is prohibited unless further disclosure is expressly permitted by the person to whom it pertains, DYS in the case of youth records, or applicable federal and /or state laws.

Copy to parent/individual: Initial/Date _________________