

**INFORMED CONSENT FOR THE RELEASE OF DATA
USE ATTACHMENTS IF NECESSARY**

I, _____
(Name of individual authorizing release)

authorize _____
(Name of individual, entity, or person holding record)

to disclose to _____
(Name of individual, entity, or person to receive the data)

the following information:

If you are requesting data as a parent regarding your minor child, write all mailing addresses below for the child to receive mailed correspondence from the County regarding this data request:

Information authorized for release shall include:

All information unless specified otherwise in the following line: _____

("All information" includes all categories below so if that box is marked, no need to mark separate record boxes below)

- | | | |
|--|--|--|
| <input type="checkbox"/> Admission and Discharge Summaries | <input type="checkbox"/> Medical Records | <input type="checkbox"/> Court and Court Services Records |
| <input type="checkbox"/> Assessment/Screening Reports | <input type="checkbox"/> School Records | <input type="checkbox"/> Treatment Plan and Progress Summaries |
| <input type="checkbox"/> Social Services Agency Records | <input type="checkbox"/> Social History | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Chemical Health Records | <input type="checkbox"/> Other Records _____ | |

Reason for release (required for the release of chemical health information)

- | | | |
|---|---|---|
| <input type="checkbox"/> Person's request | <input type="checkbox"/> Review person's current care | <input type="checkbox"/> Treatment / Continued care |
| <input type="checkbox"/> Payment | <input type="checkbox"/> Insurance application | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Other _____ | | |

Chemical Health information is protected by Federal confidentiality rules (42 CFR Part 2). A record which has been disclosed is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit further disclosure of such records unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65

I understand this data may be protected under state and/or federal privacy laws and may not be disclosed without my written consent unless otherwise provided for by state or federal law. I understand once this data is released it may be subject to further disclosure without my written consent. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it and in any event this consent expires or as described below, whichever is earlier.

I may stop this consent at any time by writing to the organizations, facilities, and/or individuals listed above. If the organizations, facilities and/or individuals listed above have already released and exchanged information based on my consent, my request to stop this consent will not work for that information.

I understand that when health information is released and exchanged between the parties listed above, the information could be redisclosed by a third party that receives it and may no longer be protected by federal or state privacy laws.

I understand that if the agencies listed above are health care providers, they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

This release expires in one year unless otherwise indicated by date or condition (state condition on line below if applicable):

Signature of Individual

Date

OR

Signature of Parent/Guardian (if applicable)

Date

State of _____

County of _____

Signed or attested before me on _____ (date) by _____ (name(s) of person(s)).

(Apply Seal Below)

Signature of notarial officer

My Commission expires: _____
