Authorization of Release of information

don't grow up invisible
YPI

Client _____ Date of Birth ___/___/_____ Age: _____
Client Address: _____

I heareby authorize Youth Pride, Inc. to ☐release ☐obtain information to/from the following:
Name: _____
Organization: _____
Address: _____
Phone: _____ Fax: _____

The method of release: ☐☐ Telephone/Verbal ☐☐ Printing Materials ☐☐ Both

The following information contained in the record of the above client pertaining to services provided on or about _____

The following confidential information may be released:

☐Educational Information
☐History
☐Treatment Plan/Progress
☐Psychiatric Evaluation
☐Medical Data
☐HIV/AIDS Data
☐Other (specify) _____
☐Legal Involvement
☐Substance Use/ Abuse
☐Discharge Summary/ Plan
☐Psychological Testing
☐Safety Planning
☐Domestic Violence

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to program participation and when appropriate, coordination of service delivery.
If other purpose, please specify: _____
I understand that I may revoke this consent at any time except to the extent action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

☐☐Upon termination of services
☐☐Three months after termination of services
☐☐Other (specify) _____

I understand that Youth Pride, Inc. will not condition my treatment on whether I give authorization for the requested disclosure.
I understand State and Federal law prohibit the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains.

_____ _____ ☐
Signature of Client Date Check here if client refuses to sign

_____ _____ _____
Signature of Parent or Guardian (if under 18 Relationship to Client Date

_____ _____
Signature of Witness Date