Unified Release of Information **Wraparound Initiative** v.5.2011

Date: ______________________________ SSN#:______________________________

Youth's Name: ______________________________ Date of Birth:______________________

Section A1: Use or Disclosure of Health/Education Information	**Section A2: Use or Disclosure of Health/Education Information**
By signing this form, I authorize the disclosure of my individually-identifiable health/education information ***BY*** the following: ☐ Juvenile Court ☐ Care Management Entity (specify) ___________________ ☐ Department of Juvenile Justice ☐ Department of Family and Children Services ☐ Mental Health Provider(s) (specify): _________________ ____ ☐ School(s) (specify): _______________________________ ☐ Wraparound Evaluation Team ☐ Medical Provider (specify): _________________________ ☐ Other organizations providing services to you and your family (specify) __________________________________, ________________________, ________________________ ☐ Other ____ ☐ All of the above (specify where necessary)	By signing this form, I authorize the disclosure of my individually-identifiable health/education information ***TO*** the following: ☐ Juvenile Court ☐ Care Management Entity (specify) ___________________ ☐ Department of Juvenile Justice ☐ Department of Family and Children Services ☐ Mental Health Provider(s) (specify): _________________ ____ ☐ School(s) (specify): _______________________________ ☐ Wraparound Evaluation Team ☐ Medical Provider (specify): _________________________ ☐ Other organizations providing services to you and your family (specify) __________________________________, ________________________, ________________________ ☐ Other ____ ☐ All of the above (specify where necessary)

Section B: Scope & Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (check one):

- ☐ All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
  - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
  - Services provided by the above agencies during the period of this release
  - Services provided by the above agencies prior to this release
  - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
  - Privileged communications between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- ☐ All health information about me as described in the preceding checkbox, excluding the following:

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- ☐ Specific health information **including only** the following:

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- ☐ All education information about me, including education records. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is the following:____

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Section D: Expiration

NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure

Event____

If no expiration even is used, consent for Release of Health Information **expires 12 months** from the date it was signed.

Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

Section E: Other Important Information

1. I understand that the System of Care agencies cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the System of Care in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.

Date	Signature of Youth
Date	Signature of Parent/Legal Guardian
Date	Signature of Witness (Title):