



I hereby authorize Catholic Social Service to exchange personal health information between Catholic Social Services

And: Name: _____ Fax: _____

Address

For: _____

Youth Name

Date of Birth

Please return form to Attention:

Catholic Social Services Teen Home Program Manager
 1513 Wintergreen Anchorage, Alaska 99508
 (fax) 277-2326

Information to be released/requested for the following purpose:

- Treatment Intake Process Legal Request Other

Please check information to be released:

<input type="checkbox"/> Biopsychosocial Summary	<input type="checkbox"/> Medical History/Physical Exam	<input type="checkbox"/> Consultations
<input type="checkbox"/> Neuropsychological Assessment	<input type="checkbox"/> Psychological Assessments	<input type="checkbox"/> U A Results
<input type="checkbox"/> Treatment Plan and reviews	<input type="checkbox"/> Psychiatric Assessment	<input type="checkbox"/> Medical / Dental
<input type="checkbox"/> Substance Abuse assessments	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> other
<input type="checkbox"/> Intake/Mental assessment	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Medical &lab Results
<input type="checkbox"/> School Records (transcripts,disciplinary reports,IEP,other plans)	<input type="checkbox"/> Discharge/Continuing Care	
<input type="checkbox"/> Verbal exchange of all information to aid in assessing and /or treating youth		

This information maybe used for continuation of care .I understand this authorization will expire on _____ and /or 6 months following the date of discharge from Catholic Social Services Teen Home, revocation of custody or guardianship, or upon written revocation, whichever comes first. This authorization may be revoked prior to the expiration, but not retroactively. Photo static and/or facsimile copies of this authorization will be considered as valid as the original.

PROHIBITION ON REDISCLoure: This information has been disclosed to you from records whose confidentiality is protected by federal law; Federal regulations (42CFR part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations restrict any use of this information to investigate or prosecute any alcohol or drug abuse patient. Disclosure of patient information is written with the patients written consent:however,disclosures to central registries and in connection with criminal justice referrals must meet the following specific regulations(42CFR 2.32 and 2.33) This information disseminated from Catholic Social Services

I acknowledge that the information to be released is protected by Federal law and may include information regarding drug/alcohol abuse, sexual transmitted diseases/HIV and /or Hepatitis B .My signature below authorizes the release of this information. I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that once the above information is disclosed. it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Client: _____

Date: _____

Parent/Guardian: _____

Date: _____