Authorization To Disclose Health Information

Patient's Full Name ______________________ Date of Birth __________ Social Security Number ______________________

I hereby authorize the persons or organizations listed on the attached page to disclose the following protected health information about the above named patient to **Youth Home, Inc.**

The following protected health information shall be disclosed pursuant to this Authorization. **A separate authorization is required for disclosure of psychotherapy notes**.

☐	Facesheet	☒	Progress Notes
☒	Summary of Initial Assessment	☐	Birth Certificate
☒	Psychiatric Evaluation	☐	Social Security Card
☒	Psychosocial Assessment	☐	Immunization Record
☐	Treatment Plan	☐	Case Management Plan
☒	Treatment Plan Reviews/Case Reviews	☒	Neurological Consultations/Testing
☒	History & Physical/Physical Exam	☒	Laboratory Reports
☒	Psychological/Psychoeducational Evaluation/s	☐	Radiology Reports/EEG
		☒	Discharge Summary/Discharge Note
☐	Speech/Language/Hearing Assessment	☐	Other (Specify): ______________________
☒	Other Educational Testing/School Records		

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm. Reasonable copying costs may be assessed.

NOTICE TO PATIENT/PATIENT REPRESENTATIVE: Certain information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be disclosed from the persons or organizations on the attached page for the following reasons:

☒	Assessment & Evaluation	☐	School Placement
☐	Treatment Planning/Continuity of Treatment	☐	Legal Reasons
☐	Coordination of Community Services/Discharge Planning	☐	PATIENT'S REQUEST
☐	Other (Specify):		

This authorization will expire: ☒ 90 days from the date of the signature,
☐ 90 days following date of discharge of patient from Youth Home, Inc.,
Or ☐ other: ______________________

This Authorization may be revoked by notifying Youth Home, Inc. in writing addressed to:
Attention: Privacy Officer
Youth Home, Inc.
20400 Colonel Glenn Road
Little Rock, Arkansas 72210
Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective only as of the date it is received by Youth Home, Inc.

I also authorize release of information regarding:
☒ Alcohol and/or Substance Abuse ☒ HIV/AIDS or other communicable diseases

NOTICE TO RECIPIENTS OF ALCOHOL AND/OR SUBSTANCE ABUSE INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

______________________ ______________ ______________
Personal Representative's Signature (generally parent/guardian) Date Relationship/Authority

______________________ ______________
Patient Signature Date

This Authorization is voluntary. A refusal to sign will **not** affect the patient's ability to obtain treatment, payment, or, if applicable, enrollment in a health plan or eligibility for benefits. A photocopy or fax of this Authorization shall be as valid as the original.

Mandatory Attachment to Authorization

Persons or Organizations Authorized To Disclose/Receive Health Information*

Patient's Full Name ____________ Date of Birth ____________ Social Security Number ____________

Please include the name of professionals or organizations, the city, and telephone number including area code.

This should include all previous and current inpatient and outpatient treatment facilities, primary care physicians, and other doctors or therapists that have provided treatment to the patient.

NAME OF PROFESSIONAL / ORGANIZATION / CITY / PHONE / DATES:
Treatment within the past two years:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

Treatment over two years ago:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

* Persons listed on this page are authorized to disclose information as indicated on the attached page 1 of the authorization. When the full 2-page authorization is sent to the persons listed above, portions of the list may be blocked for patient privacy purposes.