AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Full Name: _____ ***DOB:*** _____

☐ I hereby authorize the Virginia Department of Juvenile Justice to share my Confidential Information with the following entities/individuals for the purposes of Compliance Monitoring, Service Coordination & Treatment Planning, Eligibility Determination, Utilization Review, and the Procurement of Services. Information may be shared in the form of written information, computerized data, in meeting, or by phone.

☐ I hereby authorize Evidence Based Associates (EBA) and AMIkids (AMI), service coordination companies for the Department of Juvenile Justice, to share my Confidential Information with the following entities/individuals for the purposes of Service Coordination & Treatment Planning, Eligibility Determination, Utilization Review, and the Procurement of Services. Information may be shared in the form of written information, computerized data, in meeting, or by phone.

Authorized Recipients: *(Indicate which entities/individual may receive Confidential Information)*

- ☐ Behavioral Health & Developmental Services (DBHDS)
- ☐ Community Services Board (CSB)
- ☐ Children's Services Act (CSA) Coordinator
- ☐ Court Service Unit (CSU) / Dept. of Juvenile Justice (DJJ)
- ☐ Department of Social Services (DSS)
- ☐ Magellan or Other PPO/HMO: _____
- ☐ Providers subcontracted with EBA and AMI
- ☐ Providers coordinated through local VJCCCA offices
- ☐ Department of Education and local school system _____
- ☐ Others: _____

Confidential Information: *(Check "All Available Records" or indicate individual types of information you consent to share)*

☐ **ALL AVAILABLE RECORDS**

- ☐ Assessment Information
- ☐ Benefits / Services Needed
- ☐ Criminal Justice Records
- ☐ Educational Records
- ☐ Financial Information
- ☐ Mental Health Diagnosis
- ☐ Planned/Received Treatment
- ☐ Psychological Records
- ☐ Psychiatric Records
- ☐ Medical Diagnosis / Records
- ☐ Infectious Diseases (includes sexually transmitted diseases)
- ☐ Family Planning
- ☐ Substance Abuse Screenings / Drug Tests / Assessments
- ☐ Other: _____

Substance Abuse and Mental Health Records: This information may have been disclosed to you from records protected by federal confidentiality rules (42 CFR PART 2). FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION 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.

Right to List of Recipients and Expiration or Rescission of Consent

I can request a list of the specific entities/individuals to which/whom my information has been disclosed at any time, by submitting a written request to DJJ, EBA or AMI. Unless otherwise revoked authorization will expire one year from the date signed, or within 30 days of my case being closed to the Department of Juvenile Justice, whichever comes earlier. I understand this Authorization is subject to revocation at any time, except to the extent that the lawful holder of Confidential Information that is permitted to make the disclosure has already acted in reliance on such Authorization. To revoke this Authorization, I must do so in writing to DJJ, EBA or AMI.

Voluntary Signing: I understand that authorizing the disclosure of this Confidential Information is voluntary. I can refuse to sign. I understand that Confidential Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however, the recipient may be prohibited from disclosing substance abuse information.

Client Signature: According to § 54.1-2969 (E) of the Code of Virginia, a minor shall be deemed an adult for the purposes of consenting to medical or health services for infectious diseases (including venereal diseases), family planning, substance abuse, and mental illness. The minor is deemed an adult for the purpose of disclosing medical records pertaining to such services. Parents / Legal Guardians cannot provide consent to release these records.

I have carefully read (or had read to me) and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information to entities/individuals listed above.

Client's Signature: _____ **Date:**_____
(Required for clients 18 or older as well as for clients consenting to release of certain information as outlined above.)

Authorized Signature: _____ **Date:** _____

Relationship to client: ☐ Self (client over 18) ☐ Parent ☐ Guardian ☐ Other (List) _____

Witness' Signature: _____ **Date:** _____