System of Care
Unified Release of Information

Date: _____ Case#: _____

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 ☐ Department of Juvenile Justice ☐ DBHDD ☐ Public Schools ☐ Behavioral Health Provider ☐ Family Connection ☐ Georgia Vocational Rehabilitation Agency ☐ Department of Public Health ☐ Division of Family and Children Services ☐ Other _____	By signing this form, I authorize the disclosure of my individually-identifiable health/education information **to** the following: ☐ Juvenile Court ☐ Department of Juvenile Justice ☐ DBHDD ☐ Public Schools ☐ Behavioral Health Provider ☐ Family Connection ☐ Georgia Vocational Rehabilitation Agency ☐ Department of Public Health ☐ Division of Family and Children Services ☐ Other _____

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.
- Information concerning the testing for HIV (Human Immunodeficiency Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communication between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communication with them.

☐ All health information about me as described in the preceding checkbox, excluding the following:
_____
_____
_____

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

☐ All education information about me. 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 (check one):

☐ Specifically, the following _____
_____

☐ The youth chooses not to disclose the purpose. **NOTE**: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D: Expiration

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

Event _____

Consent for Release of Health Information expires **15 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):