■ Present this request form and valid photo identification in person or have form notarized. Fax notarized form to 208.465.8484 or email to contactus@idjc.idaho.gov

■ For medical and mental health records, complete the *Consent for Use and Release of Health/Mental Health Information* (DJC-084) form linked [here](http://www.idjc.idaho.gov/wp-content/uploads/2024/03/084.docx) or found on our website at [www.idjc.idaho.gov](http://www.idjc.idaho.gov) in About/Forms.

1. ***Name and Information of Former/Adult Juvenile or Parent/Legal Guardian Authorizing Release of Records.***

Name: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address, City, State, Zip:

Relationship to Juvenile: [ ]  Self [ ]  Parent/Legal Guardian

Juvenile’s Name (if not self) Date of Birth: IJOS#

1. ***Statement of Request and Authorization.***

I, *(printed name of adult juvenile or parent/legal guardian)* , do hereby request and authorize the Idaho Department of Juvenile Corrections (IDJC) to release the records indicated by my initials below to:

Name: Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Custody Dates Polygraph \_\_\_\_\_ Progress Reports \_\_\_\_\_ Drug & Alcohol Treatment

\_\_\_\_\_ Psychosexual Evaluations \_\_\_\_\_ Clinical Assessment Report Psychosocial Evaluations

\_\_\_\_\_ Student ID Education \_\_\_\_\_ Interstate Compact Other:

I understand that the above records are protected under federal regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and/or Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in these regulations. Recipients of this information may not re-disclose this information, except in connection with their official duties. I understand that this authorization is subject to revocation by me, if provided in writing, except to the extent the disclosure has already occurred in reliance upon this authorization. I understand that I am not required to execute this release and that I may refuse to do so and no treatment or benefits eligibility is conditioned on its execution. This authorization expires one year from date signed, or upon my death.

1. ***Authorization and Release of Liability.***

I release and forever hold harmless the state of Idaho, IDJC, and their agent(s) and/or employee(s) from and against all claims, damages, or liability resulting from any action taken pursuant to this request. I understand my authorization and release is valid for this specific request only and may be revoked by me at any time in writing to the IDJC, except to the extent IDJC has acted to disclose information in reliance upon this request. If I do not revoke my authorization and release, I understand it will expire in one year. Further, I understand that a photocopy of this request is to be honored as the original.

IDJC employee who verified identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How ID was verified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Person Requesting and Authorizing Release of Records Date signed

***4. Notary section.***

State of County of

On , 20 , personally appeared before me,

 Who is personally known to me. Whose identity I proved on the basis of .

 Whose identity I proved on the oath/affirmation of , a credible witness, to be the signer of the above instrument and he/she acknowledged that he/she signed it.

 (seal) Notary Public

 My commission expires: