**Part 1: CONSENT FOR USE AND RELEASE OF HEALTH INFORMATION**

Name of juvenile whose medical records are to be released (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/We \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the Idaho Department of Juvenile Corrections (IDJC) to release my/my child’s medical records, as allowed by applicable laws, including:

\_\_\_ Labs/laboratory results \_\_\_ X-rays \_\_\_ Medication list \_\_\_ Physical exam \_\_\_ Hearing screenings

\_\_\_ Vision screenings \_\_\_ Dental records \_\_\_ Immunizations given by the IDJC \_\_\_ Mental health progress notes

Send records to *(who/address)*:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Or, I would like to limit the disclosure to the following information *(what)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If any of the information to be released is in relation to mental health treatment, I/we acknowledge that the accompanying Consent for Use and Release of Mental Health Information (Part 2) must be completed.**

The information will be used / disclosed for the following purposes *(why – i.e. continuing care, personal, legal)*:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(date*), or on the occurrence of the following event:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or upon my death, whichever occurs first.

I understand that the above records are protected under federal regulations including the Health Insurance Portability and Accountability of 1996 (HIPAA), 45 CFR 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.

I/we acknowledge that IDJC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I/we release IDJC and its agents and employees from all legal liability that may arise from this authorization.

Signature of Person(s) Requesting and Authorizing Release of Records

Date Authorized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the signature above is not that of the juvenile whose medical records are authorized to be released, I/we certify I am/we are the parent(s) or guardian(s) of the juvenile and am/are entitled to execute this release on behalf of my/our minor child/ward.*

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

***Notary section.***

State of County of

On this\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 , *(name)* 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 Signature

 My commission expires:

Part 2: CONSENT FOR USE AND RELEASE OF MENTAL HEALTH INFORMATION

**Idaho code § 16-2428 states that juveniles over the age of fourteen (14) have the right to direct the disclosure of their mental health records in most circumstances. In accordance with this law, the following consent is required for the release of mental health information.**

Name of juvenile whose mental health information is to be released (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To be filled out by parent or guardian of juvenile 13 years old or younger:*

I/We, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent(s) or guardian(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a juvenile either previously or currently in the custody of IDJC, hereby allow IDJC to exchange all mental health treatment records concerning this juvenile with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in order to offer the appropriate treatment to the juvenile. This release is intended to cover only mental health treatment records or documentation in the possession of the IDJC.

*To be filled out by juvenile 14 years or older:*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a juvenile either previously or currently in the custody of IDJC, hereby certify that I am fourteen (14) years of age or older and authorize and allow IDJC to exchange all mental health treatment records concerning myself with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in order to offer the appropriate treatment. This release is intended to cover only mental health treatment records or documentation in the possession of the IDJC.

I/we understand that the above records are protected under federal regulations including the Health Insurance Portability and Accountability of 1996 (HIPAA), 45 CFR 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 only 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 will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(date*), or on the occurrence of the following event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or upon my death, whichever occurs first.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature (if aged under 14) and Date Parent Signature (if aged under 14) and Date

Juvenile Signature (if aged 14 and over) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***Notary section***

State of County of

On this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20 , *(name)* 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 Signature

 My commission expires: