



CONSENT FOR RELEASE OF INFORMATION

Person's Full Name

Date of Birth

Social Security Number

Individual Case Number

The following agency(s) have my permission to exchange/give/receive/share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating, and or providing service for the above named person. (Please identify all agencies that apply). **Do NOT Check boxes; Please initial all that apply.**

- | | |
|--|---|
| <input type="checkbox"/> Re-Education Services, Inc. | <input type="checkbox"/> TFC/ Respite providers |
| <input type="checkbox"/> Juvenile Justice System | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Laurelwood Hospital | <input type="checkbox"/> Crossroads |
| <input type="checkbox"/> Department of Human Services | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> East Shore | _____ |
| <input type="checkbox"/> Family Member (Specify) _____ | <input type="checkbox"/> Other _____ |

I authorize exchanging/giving/receiving/sharing/re-disclosing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual:
(Circle yes or no and initial)

- | | | |
|------------|---------|--|
| Circle One | Initial | |
| Yes No | _____ | Identify information: name, birth date, sex, race, address, and telephone number |
| Yes No | _____ | Social Security Number |
| Yes No | _____ | Case Information: The above information, plus medical (except for HIV, AIDS, and drug and alcohol treatment records), and social history, treatment/service history psychological evaluations, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), transition plans, vocational assessments, grades, attendance, and other personal information regarding me or the individual named above (disability, type of services being received and of the agency providing services to me or the individual named above). |

Information regarding the following shall not be released unless initialed below:

- | | | |
|------------|---------|--|
| Circle One | Initial | |
| Yes No | _____ | Other |
| Yes No | _____ | Substance abuse diagnosis and treatment. |

I understand that this Consent for Release of Information expires 180 days from the date it is signed unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to Re-Education Services, Inc. The revocation does not include any information which has been shared between the times that I gave permission and the time that it was canceled.

I understand that my signing or refusing to sign the consent will not affect public benefits or services that I am eligible for.

This consent expires on September 15, 2018.

_____	____/____/_____
Signature of Person	
_____	____/____/_____
Signature of Parent/Guardian	
_____	____/____/_____
Witness/Agency Representative	

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

If the records released include information of any diagnosis or treatment of drug and alcohol abuse the following statement applies: Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without specific, written and informed release of the individual to who it pertains, or as otherwise permitted by state law.

The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the person, to whom it pertains, Juvenile Court/DYS in the case of Youth records, or applicable federal and/or state law, expressly permits the further disclosure.