Authorization to Release & Exchange Information Within The System of Care

Child's Name		Date of Birth	
Child's ID #		Parent/Guardian	

I hereby authorize the disclosure and receipt of the following protected health information

(please initial in front of the items below, indicating that you agree to share the noted information).

	Admission Assessment & Screening		Alcohol or Drug History & Treatment* *Specifically note what is to be released in "OTHER"* below. **If over the age of 12 – child must also sign: ______________________________**
	Discharge Evaluation		Medication History
	Psychiatric Evaluation		Psychological Evaluation
	Progress Notes from: to		School Performance & Attendance Information
	Juvenile Justice Assessment & Service Plan		Mental Health Treatment Plan & Diagnosis
	Other*		

This information will be used for the specific purpose(s):

- To make the application for services easier for my child and family if and when we need them;
- To coordinate the services that are delivered to my child and family;
- To collect data for use in evaluating this system of service delivery

Other	*Parent/Guardian Initial Here*

Agencies and individuals participating in Alamance System of Care may include:

(initial beside each child-serving agency with whom you wish to share the above initialed information):

	Alamance-Burlington School System (ABSS)		Alamance County Law Enforcement Agencies
	Alamance County Social Services		Alamance County Health Department
	Alamance County DJJDP		Alamance County District Attorney's Office
	Alamance Regional Medical Center		Guardian Ad Litem
	Crossroads Sexual Assault Response & Resource Center		Alamance-Caswell LME
	Exchange Club Family Center in Alamance		Alamance System of Care (SOC) Review
	Alamance County Dispute Settlement & Youth Services		Family Abuse Services
	Mental Health Provider(s) Specify:		Other

Once information is disclosed pursuant to this signed authorization, I understand that the Federal Privacy Law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from disclosing it. When mental health and developmental disabilities information is disclosed it is protected by state law (G.S. 122C) or substance abuse treatment information protected by Federal Law (42 C.F.R. Part 2), the recipient of the information is informed that re-disclosure is prohibited except as permitted or required by these two laws.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. If not revoked earlier, this authorization expires automatically one year from the date it is signed. I understand that I may refuse to sign this authorization form. I understand that the Alamance System of Care will not condition my child's treatment on receiving my signature on this authorization. I certify that this authorization is made freely, voluntarily and without coercion. I understand that ONLY the information noted above will be disclosed. If additional information is needed I will be asked to sign an authorization for the disclosure of that protected information. **This consent is valid until _________________ or for not more than 12 months.**

______________________________________ ____

Signature of Parent/Legal Guardian Date

______________________________________ ____

Signature of Service Provider/Staff Agency Date

Revocation Date: ____________________ Signature: __________________________________