Youth For Tomorrow
Joe Gibbs Founder

AGENCY AUTHORIZATION TO DISCLOSE OR REQUEST PROTECTED HEALTH INFORMATION

Directions: Fill in all blanks. Write N/A if not applicable.

1. I,_____/ _____
Individual's Name (Please Print) *Date of Birth*

2. Authorize Youth For Tomorrow to ___**Exchange with…** ___**Release to…** ___**Receive from…**

3. The following Provider/Organization/Individual
Name:_____
Address:_____
City/State/Zip:_____
Phone: _____

4. The following information:

__ Assessment __ Diagnostic Evaluation __ Discharge Summary __ HIV/AIDS/STD Status

__ Medical Records __ OT/PT/ST/ED Evaluation Results __ Progress Notes __ Substance Use Information

__ Treatment Plan Treatment Summary Other (may include a partial release) _____

5. This authorization allows the indicated providers to share information described above for:

___ A single disclosure at the time of authorization ___Ongoing use or disclosure during the time period specified above

6. These records (*select only one):*

___ **ARE** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR, Part 2). If these records are protected by 42 CFR, Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

___ **ARE NOT** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal HIPAA regulations.

7. I understand that:

- Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above.
- The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
- If I am participating in this program as a condition of probation, parole, or release from confinement, I may not revoke consent for unlimited communication between Youth for Tomorrow and the criminal justice system until final disposition of my case.
- I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.
- When I authorize Youth for Tomorrow to disclose information to third parties, Youth for Tomorrow is unable to prevent re-disclosure of this information by the recipient.
- The information to be released has been fully explained to me and this authorization is given to me of my own free will.
- I am entitled to a copy of this signed authorization.

8. This authorization expires as described: _____
Date, event, or condition upon which this consent will expire

Signature of Client_____ Date _____

Signature of authorized representative (if applicable)_____ Date _____

☐Parent ☐Guardian ☐Legally Authorized Representative ☐Other_____

Please print representative's name _____

This information should be returned to_____(YFT Staff) at the address checked below:

☐YFT Main Campus: 11835 Hazel Circle Drive, Bristow, VA 20136; (703) 368-7995; Fax (703) 361-4335
☐BHS Woodbridge: 14000 Crown Court, Suite 101, Woodbridge, VA 22193; (703) 659-9900; Fax (571) 285-5686
☐BHS Manassas: 9720 Capital Court, Suite 302, Manassas, VA 20110; (703) 659-9900; Fax (571) 364-8913
☐BHS Gainesville: 7130 Heritage Village Plaza, Ste. 102 Gainesville, VA 20155; (703)-955-3187; Fax (703)-743-1688
☐BHS Springfield: 6800 Backlick Road Springfield, Ste 300 VA 22150; (703)-310-7449; Fax (866)295-9344.