

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

DIVISION OF FAMILY SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize

To Release Information TO: \_\_\_\_\_

To Obtain Information FROM: \_\_\_\_\_

The type of information to be disclosed is:

The purpose of this information disclosure is:

This authorization is valid until:

\_\_\_\_\_ Six months from the date of signature

\_\_\_\_\_ The following date \_\_\_\_\_

This consent may be revoked at any time, except to the extent that action has been taken in reliance on it. The person completing this form has a right to receive a copy. This form is invalid unless all sections are completed.

\_\_\_\_\_  
Client Signature (if applicable)                      Print Name                      Date

\_\_\_\_\_  
Parent, Guardian, Custodian (Circle One)                      Print Name                      Date

\_\_\_\_\_  
DFS Worker                      Print Name                      Date

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 {"HIPAA"}, 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.