DSCYF
Department of Services for Children Youth & Their Families

PART I: AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information

Name*:_____ Date of Birth:_____
Name*:_____ Date of Birth:_____
Name*:_____ Date of Birth:_____
Name*:_____ Date of Birth:_____
**Person(s) for whom information will be released and/or received*

Recipient Information

I, _____, (please circle one: self/parent/guardian/custodian), provide consent for an authorized representative of the Department of Services for Children, Youth, and Their Families (DSCYF) to:
Please ***initial the appropriate line(s) and check the appropriate box(es)***

___ release client's Information to the following individual or authorized organization representative:

___ receive client's Information from the following individual or authorized organization representative:

☐ Parent/Guardian
☐ Substance Treatment Provider (please specify): _____
☐ School (please specify): _____
☐ Legal Counsel (Name): _____
(Contact Information): _____
☐ Primary Care Physician: _____
☐ Other (please specify): _____
☐ Other (please specify): _____
☐ Other (please specify): _____

The purpose of this exchange of information is to provide services or representation to the client or to present the client's case in court.

Description of Information to be Released

Information to be Released: All information, including but not limited to: educational, medical and mental health diagnoses and treatment (whether verbal, written, or electronic). Information regarding the following confidential matters will not be released to non-DSCYF representatives unless required by law or expressly indicated below: acquired immune-deficiency syndrome (AIDS), or human immuno-deficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C, or genetic information. *(Please use the space below to specify any additional information to be released or excluded):*

_____

_____

Substance Use Disorder Information to be Released: All information including, but not limited to: treatment assessments and progress, drug screens and discharge summaries (whether verbal, written or electronic). ***Authorization for the disclosure of substance use disorder information requires a separate signature under Part II of this form.***
(If applicable, please use the space below to specify additional substance use disorder information that may be disclosed or excluded):

_____

_____

Please disclose the above described information to the above identified individual or authorized organization representative. I understand I may inspect or copy the information released and may request a list of the people information has been disclosed to, as provided in 45 *CFR* §164.524 and 42 CFR 2.13.

I also understand that reports and/or documents from third party providers not under contract with DSCYF or its divisions will not be released under this authorization and must be requested directly from such third party provider.

I have been made aware that even without this signed authorization, the Health Insurance Portability and Accountability Act ("HIPAA") allows sharing of protected health information, without client authorization, for the purpose of treatment, payment, and operations.

I understand that I can revoke this authorization for the release of the client's information, in writing, to the DSCYF Privacy Officer (DSCYF_Revocations@delaware.gov or fax (302) 661-7267), at any time prior to its designated expiration. I understand that the revocation will not apply to information that has already been released in reliance on this authorization.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this release for the client to be provided mental health treatment. If the client is provided treatment by DPBHS, a separate authorization will be needed to determine whether the client qualifies for their services and benefits.

I further understand that once information is disclosed, there is a potential for an unauthorized re-disclosure, which will cause the federal confidentiality rules to no longer protect it. If I have any questions about the disclosure of the client's information, I can contact the DSCYF Privacy Officer.

Expiration Date

This release of information is valid for:
☐ 365 days from the date of the signature below; or unless less than a year and specified below
☐ *(Please indicate duration of release)* _____

_____	_____	_____
Self/Parent/Guardian/Custodian Signature	Print Name	Date

PART 2: ADDITIONAL AUTHORIZATION FOR DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

I understand that I can revoke this authorization for the release of the client's substance use disorder information, in writing or orally to the DSCYF Privacy Officer, at any time prior to its designated expiration. I understand that the revocation will not apply to information that has already been released in reliance on this authorization.

I understand that Federal rules restrict any use of substance use disorder information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that any information related to substance use disorder services or treatment is protected under the confidentiality provisions of 42 *CFR* Part 2 and cannot be further disclosed without written consent, unless expressly authorized in this authorization or otherwise permitted by 42 *CFR* Part 2. **I understand that the signature(s), immediately below, authorize(s) the release of client's substance use disorder records, as described with specificity in Part I of this release.**

_____	_____	_____
Self/Parent/Guardian/Custodian Signature	Print Name	Date
_____	_____	_____
Minor Signature (If age 14 or older)	Print Name	Date

The client shall receive a copy of this signed authorization.
A copy of this authorization shall have the same force and effect as the original authorization.