



MAAC PACT Unified Release of Information

Date:		Case #:	
Youth's Name:		DOB:	

Section A1: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my individually-identifiable health/education information **by** the following:

<input type="checkbox"/> Juvenile Court
<input type="checkbox"/> Department of Juvenile Justice
<input type="checkbox"/> Mental Health Center
<input type="checkbox"/> Schools
<input type="checkbox"/> Amerigroup
<input type="checkbox"/> Division of Family and Children Services
<input type="checkbox"/> Program Evaluator
<input type="checkbox"/> Any other organization providing services to you and your family
Other

Section A2: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my individually-identifiable health/education information **to** the following:

<input type="checkbox"/> Juvenile Court
<input type="checkbox"/> Department of Juvenile Justice
<input type="checkbox"/> Mental Health Center
<input type="checkbox"/> Schools
<input type="checkbox"/> Amerigroup
<input type="checkbox"/> Division of Family and Children Services
<input type="checkbox"/> Program Evaluator
<input type="checkbox"/> Any other organization providing services to you and your family
Other

Section B: Scope & Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows:

- All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
 - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
 - Services provided by the above agencies during the period of this release
 - Services provided by the above agencies prior to this release
 - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
 - Privileged communications between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- All health information about me as described in the preceding checkbox, excluding the following:

Specific health information including only the following:

All education information about me, including education records. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is (check one):

Specifically, the following The provision of care coordination and support.

The youth chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D: Expiration

NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure

Event Discharge from the MAAC PACT Program.

Consent for Release of Health Information expires 12 months from the date it was signed. Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

Section E: Other Important Information

1. I understand that the System of Care agencies cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).

2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.

3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the System of Care in reliance on this authorization before written notice of revocation is received.

4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.

Date	Signature of Youth
Date	Signature of Parent/Legal Guardian
Date	Signature of Witness (Title):