

**Bitterroot Valley Education Cooperative
YOUTH ENHANCEMENT PROGRAM**

PO Box 187

Phone: (406) 777-2494

Stevensville, MT 59870

FAX: (406) 777-2495

AUTHORIZATION TO RELEASE INFORMATION

Please note: If you are a recipient of information released by Bitterroot Valley Education Cooperative the following Federal Law applies directly to you: This information has been disclosed to you from records who confidentiality is protected by Federal Law. Federal Regulations (45 CFR Part 160 and 164; and 42 CFR Part 2) prohibit you from making any further disclosure if it is without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Child's Name: _____ **Date of Birth:** _____ **SSN:** _____

RELEASE TO: **OBTAIN FROM:**

Name or Names: _____

Agency: _____

Address: _____

Phone: _____ FAX: _____

INFORMATION TO BE RELEASED/OBTAINED (CHECK BOX)

- | | |
|---|--|
| _____ History and Physical | _____ Psychiatric Evaluation/Records |
| _____ Intake/Discharge Summary | _____ Psychological Evaluation |
| _____ C.D. Evaluation | _____ Medical Evaluation/Records |
| _____ Progress Report/Periodic Treatment Review | _____ Verbal exchange regarding patient care |

Other: _____

THE PURPOSE OR NEED FOR SUCH DISCLOSURE IS:

_____ For ongoing psychiatric services and support

_____ Other: _____

This authorization is valid for a two year period from the date of signature, unless this form contains a specification of a Date, Event or Condition upon which this consent expires: _____

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that this information will not be disclosed to anyone other than those persons participating in my treatment continuum without my written permission. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that disclosed information may be re-disclosed to additional parties and no longer protected once the person(s) listed above receive my child's health information. I understand that I may revoke this authorization at any time

The BVEC, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I authorize the use of a fax or photocopy of this form for the release or disclosure of the information described above.

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Tim Miller, Privacy Officer, Bitterroot Valley Education Cooperative, PO Box 187, Stevensville, MT, 59870. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

REVOCATION SECTION: I hereby revoke this authorization.

Signature Date