AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

Demographic Information	Name of Youth:_____ Date of Birth: _____ Address:_____ Day Phone: _____ City:_____ State:_____ Zip:_____
Receiving Party (*Where do you want the information sent? Who may have the information?*)	Name:_____ Phone: _____ Address:_____ City:_____ State:_____ Zip: _____
Information to be Released (*What do you want to be sent or released? Check the appropriate box(es).*)	☐ **Complete record** (includes ALL record types below) OR only: ☐ All ISPs (service plans and authorizations) ☐ Signed releases and other signed paperwork ☐ All formal correspondence (no-contact letters, court letters, SRTU letters, etc.) ☐ Attendance forms ☐ Strength and Needs Assessments ☐ Progress notes authored by PCE staff ☐ Service plans authored by PCE staff ☐ _____ evaluation/assessment paid for by PCE *Optional:* Include only the following dates of service: _____
Purpose for Release (*Why is it needed?*)	☐ Continuing care ☐ School ☐ Research ☐ Legal ☐ Insurance ☐ Other: _____

- This authorization lasts for one year after the date you sign it unless you enter a different date here: _____
- PCE may take up to two weeks to process this request.
- This authorization may be canceled in writing at any time by providing written notice to PCE, Attn: HIPAA Privacy Officer. A cancellation will not change releases that happened before the cancellation.
- PCE will not restrict my/my youth's treatment if I choose not to sign this authorization.
- A photocopy or other electronic copy of this authorization will be treated as an original.
- In most cases, PCE cannot provide records that we did not create or pay for. However, additional records created by other professionals and organizations may be available to you. Contact your care manager for details on how to access them.
- PCE cannot prevent re-disclosure of your information by the person or organization that receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PCE from any and all liability resulting from disclosure by the recipient.

Your signature below indicates you have read and understand this form and authorize the release of your/your youth's information as described above.

_____ _____
Signature of Individual or Legal Guardian/Legal Representative Date

_____ _____
Print name of Individual or Legal Guardian/Legal Representative Relationship to Individual