THE BRIDGE
YOUTH & FAMILY SERVICES

Release of Confidential Information

I, _____, authorize The Bridge Youth and Family Services to disclose to and/or obtain information about me/my child _____, whose date of birth is _____ from:

_____

(Name of person and/or organization/phone number)

Information to be released and/or exchanged:

_____ Assessment

_____ Discharge Summary

_____ Progress in Treatment

_____ Presence/Participation in Treatment

_____ Current Diagnosis

_____ Current Treatment Plan

_____ Psychiatric/Psychological Report (s)

_____ Educational/Behavioral Information

OTHER: (specify) _____

Purpose: This information may be used or disclosed in connection with mental health treatment.
If the purpose is other than as specified, please specify:

_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written and dated notification to _____ at _____. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires one year from the date of the authorization or 60 days after termination, whichever comes first.

The Bridge Youth and Family Services is committed to protecting client confidentiality. If staff determine that a client is vulnerable due to : (1) mental disability, (2) functional illiteracy, (3) trauma, (4) status as a child without permanent family ties, or (5) other relevant factors, it will not release confidential information that could be deemed harmful, or for purpose which appears questionable.

Condition: I further understand that The Bridge Youth and Family Services will not condition my treatment on whether I give authorization for the requested disclosure. However, I understand that by withholding authorization, me/my child may not receive the most comprehensive services and may not achieve desired results.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbal and written in both paper and electronic format.

Redisclosure: I hold harmless The Bridge Youth and Family Services and its staff regarding use of information authorized for release. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPPA privacy regulations, unless a State law applies that is more strict than HIPPA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Client (12 years or older)/Date

_____

Signature of Parent/Guardian/Date

_____

Signature of Staff Witness/Date

_____Check here is client refuses to sign authorization

A photocopy of this authorization is as authentic as the original statement of release.