

**LINN COUNTY JUVENILE DEPARTMENT
RELEASE OF INFORMATION**



To best serve the interests of you and your family, it is sometimes necessary for the Juvenile Department and other agencies to share information. By signing this form, you are giving permission for these organizations and the Linn County Juvenile Department to exchange this necessary information. Refusal to sign this authorization will not affect your ability to receive services or payment of services. The only circumstance when refusal to sign may affect your ability to receive services is if health care services require us to disclose health information to someone else and the authorization is necessary to make that disclosure.

Youth's Legal First Name		Youth's Legal Last Name		Other Names Used	
Address			Apartment No.	City	State
DOB:			JJIS Number	Primary Telephone Number	Cell Number

I hereby authorize the Linn County Juvenile Department to provide information to and/or from the agency(ies) below for the purpose of evaluating my situation, to plan for and coordinate services for me and/or my family, or for other purposes as specified:

<input type="checkbox"/> Community Services Consortium <input type="checkbox"/> Oregon Department of Human Services <input type="checkbox"/> Education Service District(s) <input type="checkbox"/> Linn County Alcohol and Drug <input type="checkbox"/> Linn County Health Department <input type="checkbox"/> Linn County Mental Health <input type="checkbox"/> Local School District/School(s)	<input type="checkbox"/> Oregon Youth Authority <input type="checkbox"/> Private Counseling/Treatment Providers <input type="checkbox"/> Residential Treatment Providers <input type="checkbox"/> Linn County Developmental Disability Program <input type="checkbox"/> Jackson Street Youth Services/Shelter Program <input type="checkbox"/> One2Another Parenting Support Group <input type="checkbox"/> Other: _____
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By checking the boxes below, I authorize the release of the following record(s), if such record(s) exist(s):

<input type="checkbox"/> Court Documents <input type="checkbox"/> Personal History and Family Data <input type="checkbox"/> Mental Health / Psychological Evaluations <input type="checkbox"/> Mental Health Treatment Documents <input type="checkbox"/> Substance Abuse Evaluations <input type="checkbox"/> Substance Abuse Treatment Documents <input type="checkbox"/> Education Records <input type="checkbox"/> Other	<input type="checkbox"/> Medical Records <input type="checkbox"/> Laboratory and Pathology Reports <input type="checkbox"/> Diagnostic Imaging / Xray / EKG / EEG Reports <input type="checkbox"/> Medical Chart Notes <input type="checkbox"/> Medical Diagnoses <input type="checkbox"/> Dental Records <input type="checkbox"/> Vision Records <input type="checkbox"/> Other
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***IMPORTANT**

If the information to be disclosed contains any of the records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV / Aids Information	_____ Mental Health Information
_____ Genetic Testing Information	_____ Drug & Alcohol Diagnoses, treatment, or referral information

The permission for this release of information is good for one year, until revoked, or until: _____

I have read this authorization and I understand the purpose of this agreement. I approve the release of this information. I understand that information about my case may be confidential and protected by state and federal law. I may cancel this authorization at any time with the understanding that information previously released will not be affected by the cancellation.

_____ Youth Name (Print)	_____ Signature Youth	_____ Date
_____ Parent/Guardian Name (Print)	_____ Signature of Parent/Guardian	_____ Date
_____ Probation Officer Name (Print)	_____ Signature of Probation Officer	_____ Date

You may cancel this authorization to use and disclose your information in writing at any time by sending a written statement stating that you are revoking this authorization, addressed to the Office Manager of the Linn County Juvenile Department. You may also cancel this authorization by appearing in person at the office where you receive services and writing REVOKED across the face of the authorization, the date, and your signature.. If you cancel your authorization, the information described above may no longer be used or disclosed for the purposes described herein. Any use or disclosure already made with your permission cannot be undone.