

Oakley School

Consent for Disclosure of Confidential Information

FOR THE RECEIPT OF THE INFORMATION:

The Federal rules prohibit you from making any further disclosure of this information unless further use of disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted under Federal rules. With respect to information regarding alcohol or drug abuse treatment, a general authorization for the use or release of medical or other information is NOT sufficient. In such a case, Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1. Pursuant to Federal Guidelines concerning my right to confidentially, I, _____
(Student Name)
DOB: _____ authorize _____
(Person/Organization making disclosure)
to release/disclose confidential information to: _____
(Person/Organization receiving disclosure)

2. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. The information to be used or released includes:

- | | | |
|---|---|--|
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Psycho-Social History |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Data | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Assessments | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Monthly Progress Report | <input type="checkbox"/> Verbal Communication with: _____ | |
| <input type="checkbox"/> Other: _____ | | |

3. The above information is to be released for the following purpose:

- For evaluative purposes to determine if the student meets admission criteria for the Oakley School.
- For continuation of care at the Oakley School.
- For continuation of care at: _____
- Other: _____

4. I authorize the release of such information by mail, fax, regular telephone, and/or cellular phone contact.

5. I understand that unless I revoke the authorization earlier, this authorization will automatically expire 60 days after the student's discharge from the Oakley School or on (date, event, condition): _____

6. I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.

7. This authorization is limited to only that information that I have requested above to be used or disclosed to the person/facilities named herein. I hereby release the Oakley School from all legal responsibilities or liability that may arise from the use of disclosure of medical records and other health information in reliance on this authorization.

8. Pursuant to Utah State rules, I understand that in case I am below the age of 18, my parent/legal guardian reserves the right to sign this release without my expressed verbal or written consent.

Certification: I certify that I am (check whichever applies):
 The student, and the identification that I have provided is true and correct.
 The student's authorized representative, and the identification and proof of authority that I have provided are thru and correct. My relationship to the student is that of: _____

Resident Signature: _____ Date: _____

Parent/Legal Guardian Name: _____ Date: _____

Witness Signature: _____ Witness Signature (by Phone): _____ Date: _____