AGENCY AUTHORIZATION TO DISCLOSE OR REQUEST PROTECTED HEALTH INFORMATION

Directions: Fill in all blanks. Write N/A if not applicable.

1. I,_____/ _____
   Individual's Name (Please Print) Date of Birth

2. Authorize Youth For Tomorrow to ___Exchange with… ___Release to… ___Receive from…

3. The following Provider/Organization/Individual
   Name:_____
   Address:_____
   City/State/Zip:_____
   Phone: _____

4. The following information:

___Assessment ___Diagnostic Evaluation ___Discharge Summary ___HIV/AIDS/STD Status

___Medical Records ___OT/PT/ST/ED Evaluation Results ___Progress Notes ___Substance Use Information

___Treatment Plan __Treatment Summary __Other (may include a partial release) _____

5. This authorization allows the indicated providers to share information described above for:

____A single disclosure at the time of authorization ___Ongoing use or disclosure during the time period specified below

6. These records (select only one):

____ARE protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR, Part 2). If these records are protected by 42 CFR, Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____ARE NOT protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal HIPAA regulations.

7. I understand that:
   - Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above.
   - The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization.
   - If I am participating in this program as a condition of probation, parole, or release from confinement, I may not revoke consent for unlimited communication between Youth for Tomorrow and the criminal justice system until final disposition of my case.
   - I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it.
   - When I authorize Youth for Tomorrow to disclose information to third parties, Youth for Tomorrow is unable to prevent re-disclosure of this information by the recipient.
   - The information to be released has been fully explained to me and this authorization is given to me of my own free will.
   - I am entitled to a copy of this signed authorization.

8. This authorization expires as described: _____
   Date, event, or condition upon which this consent will expire

Signature of Client_____ Date _____

Signature of authorized representative (if applicable)_____ Date _____

☐Parent ☐Guardian ☐Legally Authorized Representative ☐Other_____

Please print representative's name _____

This information should be returned to Darnetta Jones/Tonia Copeland (YFT Staff) at the address checked below:

☐ Main Campus: 11835 Hazel Circle Drive, Bristow, VA 20136; (703) 368-7995; Fax (703) 361-4335
☐ Woodbridge: 14000 Crown Court, Ste. 101, Woodbridge, VA 22193; (703) 659-9900; Fax (571) 285-5686
☐ Manassas: 9720 Capital Court, Ste. 302, Manassas, VA 20110; (703) 659-9900; Fax (571) 364-8913
☐ Gainesville: 7130 Heritage Village Plaza, Ste. 102 Gainesville, VA 20155; (703)-955-3187; Fax (703)-743-1688
☐ Springfield: 6800 Backlick Road, Ste. 300, Springfield, VA 22150; (703)-310-7449; Fax (866)295-9344
☐ Leesburg: 19451 Deerfield Ave., Ste. 101, Leesburg, VA 20176; (703)-955-3187; Fax (703)-743-1688