WASHINGTON COUNTY
OREGON

Washington County Juvenile Department
222 N. First Avenue, MS-47, Hillsboro, OR 97124
Phone: (503) 846-8861 Fax: (503) 846-8886

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client Name:______________________________ DOB:______________

My signature below hereby gives consent for the exchange of confidential information between **the Washington County Juvenile Department and __the Laurie C. Rice Memorial Scholarship Committee________________**

The purpose of such disclosures is to facilitate informal, pre-adjudication and probation supervision, general case planning, and the coordination of mental health counseling, alcohol and drug treatment planning and other services deemed necessary by the Washington County Juvenile Department.

The information that may be shared includes (initial all that apply):

________ Medical records and treatment records, including hospitals

________ Mental health evaluations and other mental health records

________ Psychological and/or psychiatric evaluations

________ Alcohol and drug history, evaluations and treatment records

____X___ General education records, special education eligibility records and Individualized Education Plans (IEP)

________ Psychosexual evaluations, polygraph examination results and other sex offender treatment records

____X___ Other specific information as indicated: General performance and outcomes while under supervision of Juvenile Department____________________

The information will be used for the following purposes (initial all that apply):

________ Facilitate case planning

________ Coordinate client services

________ Allow face-to-face contact at school and/or residential facility

___X ___ Other specific purpose: Decision regarding qualification for scholarship________________

I understand that my records are protected under federal regulations and Oregon statutes governing confidentiality, including those governing the confidentiality of alcohol and drug patient records. This information cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or eligibility of benefits. I may revoke this consent at any time by notifying the Washington County Juvenile Department in writing. I understand that the revocation is effective after it is received and that any use or disclosure of information made prior to the revocation will not be affected. I understand that if my information is released to an entity not covered by federal privacy regulation it may be redisclosed. *A copy of this form shall have the same validity as the original.* The Washington County Juvenile Department is neither authorized nor funded to pay fees for information received.

This authorization and consent for disclosure of confidential information will remain in effect until one year after the date of my signature, or until the termination of my informal, pre-adjudication or probation supervision with the Washington County Juvenile Department, whichever occurs first.

Youth: ____ Date: ______________

Parent/Guardian: ______________________ Relationship: ______________ Date: ______________

Witness: __________________ ____________________________ Date: ______________