Authorization for Release of Information

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

We can help you better if we are able to work with other professionals and organizations that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

I authorize Kairos to share information about:

Youth Name:_____ D.O.B.:_____ ID #: _____

with the following individual or agency:

_____ _____

_____ _____

including records of: ***(Parent or guardian and youth (if over 14) must initial each item.)***

Family History:	_____Yes _____ No	Medical/Psychiatric Treatment:	_____Yes _____ No
Employment/Unemployment:	_____ Yes _____ No	Mental Health Services:	_____Yes _____ No
Educational Reports:	_____ Yes _____ No	Genetic Testing:	_____Yes _____ No
Alcohol/Drug Treatment:	_____ Yes _____ No	HIV/Aids:	_____Yes _____No

Other, as listed:_____

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified:_____

_____

The agency and individual listed above may share and exchange information about your family and your circumstances.

This permission is good until 180 days following discharge from all Kairos services.

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Parent or Guardian Print Name	Parent or Guardian Signature	Date
Youth Print Name	Youth Signature	Date
Kairos Representative Print Name	Kairos Representative Signature	Date

To those receiving information under this authorization: **This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.**

This is a true copy of the original authorization document:_____(Kairos Representative)