SWEET HOME YOUTH SERVICES TEAM
AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

By signing this form, you are authorizing the release of information between and among the identified Sweet Home Youth Services Team members for the purposes of planning and coordinating services for your family. This authorization will allow representatives to meet and share information to develop a service plan and to share information between listed agencies for follow-up case coordination. My signature below authorizes release of information from my records and those of the children listed below.

Parent/Guardian Legal Name Last, First, MI	Date of Birth
Child Name Last, First, MI	Date of Birth
Child Name Last, First, MI	Date of Birth
Child Name Last, First, MI	Date of Birth

I authorize the following Sweet Home Youth Services Team members;
Parent Representative Community Services Consortium
Oregon Department of Human Services Linn-Benton-Lincoln ESD
Oregon Youth Authority Linn Co. Alcohol and Drug Program
Sweet Home School District Linn Co. Developmental Disabilities Program
Sweet Home Police Department Linn Co. Juvenile Department
Sweet Home Fire Department Linn Co. Sheriff's Department
Sweet Home Boys & Girls Club Linn Co. Mental Health Program
Other: _____

to release to and exchange with the other YST members listed above the following information, including oral and/or written, for the purpose of service planning and coordination:

Type of Information/Records **Medical Coverage** (Choose One)
Presence in program and services provided **( ) Private Insurance**
Educational Records **( ) OHP/Medical Card**
Family History **( ) None**
Employment/Unemployment
Legal
Service Plan
INITIAL ____ Medical/Health Services (includes diagnosis, treatment and prognosis)
INITIAL ____ Mental Health (includes diagnosis, treatment and prognosis)
INITIAL ____ Alcohol & Drug (includes evaluation and diagnosis, treatment and prognosis)
Other: _____

This authorization shall remain in force for a period of 12 months from the date of authorization unless cancelled. I can cancel this authorization at any time, but the cancellation will not affect any information that was already released before the cancellation. I understand that information about my family 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.

Authorizing Signature or Mark	Date
Minor's Signature (Required to release Alcohol & Drug Information)	Date
Witness Signature	Date

To the party receiving this information: Any information disclosed to you is from confidential records protected by State and Federal law. Federal regulations (42 CRF Part2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.

_____ This is a true copy of the original authorization document.
Full Signature of Agency Staff Person Making Copies

Revised 2-3-2010