SANTIAM 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 Santiam 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 Santiam Youth Services Team members;

- Adult and Family Services
- Canyon Crisis Center
- Linn County Services to Children and Families
- Linn County Department of Health Services
- Linn County Juvenile Department
- Linn County Sheriff's Department
- Linn Benton Lincoln ESD
- Marion County Juvenile Department
- Marion County Sheriff's Office
- North Santiam School District
- Oregon State Police
- Santiam Canyon School District
- Santiam Service Integration Team
- Scio School District
- State of Oregon Parole and Probation
- Parent Representative
- Samaritan Health Services
- Other: _____

to release to and exchange with the other YST members listed above the following information for the purpose of service planning and coordination:

Type of Information/Records
(If you object to any information listed, cross out & initial)

- Presence in program and services provided
- Educational records
- Family History
- Employment/Unemployment
- Legal
- Medical/Health Services (includes diagnosis, treatment and prognosis) **INITIALS REQUIRED**:_____
  Mental Health (includes diagnosis, treatment and prognosis) **INITIALS REQUIRED**:_____
  Alcohol & Drug (includes evaluation and diagnosis, treatment and prognosis) **INITIALS REQUIRED**:_____
- Service Plan
- Other: _____

Medical Coverage
❒Private Insurance
❒OHP/Medical Card
❒None

This authorization shall remain in force for a period of 12 months from the date of authorization unless canceled. 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 Date
(required to release alcohol and drug information)

_____ _____
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 Part 2) 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

White: YST Yellow: Parent/Guardian