Youth Behavioral Health
Psychological services for children, adolescents, and young adults
Youth Behavioral Health, LLC ● 1027 7th Street NW ● Rochester, MN 55901
Phone (507) 206-3370 ● Fax (507) 208-4016 ●http://www.youthbehavioralhealth.org/

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT INFORMATION: NAME_____DOB_____
Patient Address_____
Patient City, State, ZIP_____ Phone_____
I hereby authorize YBH to: ☐Exchange with ☐Disclose to ☐Obtain from

Individual/Agency_____
Address_____
City, State, ZIP _____
Phone _____ FAX _____

☐ Please send records ASAP ☐ Date Needed by _____

Records to be sent for the following purposes:
☐ Evaluation and treatment ☐Coordination of Care
☐ At the request of the individual or guardian ☐Other: _____

Release is to share information for dates of services: from _____ to _____

☐ **Mental Health Records (all listed/as available):**
- Psychological Testing
- Clinic Notes
- Medication History
- Therapy/Counseling Notes
- Psychiatric Evaluation
- Hospital Discharge Summary
- Diagnostic Assessment
- Chemical Dependency

☐**School Records (all listed/as available):**
- Individualized Education Plan
- Child Study Team Evaluation
- Discipline records
- Attendance records

☐ **Medical Records (all listed/as available):**
- Clinic Notes
- Med History
- Lab Results
- Neurology

☐**Other (Please specify)**
_____
_____
☐to communicate about issues/concerns via telephone
☐to communicate about issues/concerns via email

I understand that I may revoke this consent in writing at any time, as explained in YBH's Notice of Privacy Practices. I also understand that any disclosure or use hereby authorized cannot be made to anyone other than the facility or individual listed above, unless I provide such authorization, or in case of emergency. I understand that if this information is disclosed to a third party, the information may be re-disclosed by the person or entity that received the information and may no longer be protected by federal privacy regulations. I understand all of the aforementioned, and with informed consent and of my own free will, I authorize disclosure of protected health information. This authorization will automatically expire, without my expressed revocation, one year from date of signature.

X Signature: _____ Date: _____
Relationship (if not patient) _____
Witness Signature (if any)_____
☐Check if patient is 16-17 years old: **X Signature _____**