YOUTH CONSULTATION SERVICE, INC.
284 Broadway, Newark, NJ 07104
Tel. (973) 482-8411

AUTHORIZATION FOR RELEASE OF HEALTH/MEDICAL INFORMATION

1. Authorization. This shall serve as authorization for YOUTH CONSULTATION SERVICE, INC. ("YCS") to provide/release the information and records identified in Section 2 concerning:

_____

(Client's name) *(Client's date of birth)*

to: _____

(name or title of the person or organization to whom the disclosure is to be made)

_____

(address, city, state, zip, telephone and fax number of the person or organization to whom the disclosure is to be made)

The undersigned understands that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect the Client's ability to obtain treatment from YCS, except in the limited circumstances provided in Sections 4 and/or 5 below.

2. Information and Records to be Provided/Released. The undersigned hereby authorizes YCS to release to, obtain from, and/or discuss with the person/entity named above:

Initial		Initial		Initial	
	Admission Assessment		Lab finding		Treatment/Service Plan
	Correspondence		Legal Information		Other (specify):
	Diagnosis		Medical Information		
	Discharge Summary		Medication List		
	Educational Information		Psychiatric Evaluation		
	Financial Information		Psychological Evaluation		

I specifically authorize YCS to release information and records pertaining to (*indicate your authorization by initializing in the space(s) provided*):

_____Drug and alcohol abuse/treatment/evaluation
_____HIV, AIDS and/or sexually transmitted disease related information/treatment

(I understand that if I do ***not*** want either of these two categories of information/records to be released, I may limit YCS's authorization to release such information by ***not writing my initials*** in the space(s) provided.)
If there are other records/ information that I specifically do ***not*** want released, I should identify it in the following space:

_____

(If none, write "none")

_____

Notice to the authorized recipient of the information/records: The information has been disclosed to you from confidential records that are protected under federal and state laws. This information is intended only for the limited use set forth by the Client or his or her Parent/Guardian in this written authorization. You are prohibited from disclosing, copying or otherwise distributing such information to any person other than the authorized recipient(s) without first obtaining the written authorization of the Client or his or her Parent/Guardian, or as otherwise authorized by law. After the need for which this information is sought has been fulfilled, the information shall be returned to YCS or destroyed. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient

I understand that YCS will limit the disclosures it makes of Client's mental health information/records to the mental health information/records that YCS itself created, but will indicate the sources of deleted information as contemplated by the regulations of the New Jersey Department of Human Services.

To the maximum extent allowed by applicable law, I agree to release YCS and its employees and agents from all liability that may arise from the release of the information and records herein requested.

3. Purpose/Use of Information Requested. The information and records requested will be used for the Client's own purposes or, if not, then it will be used for the following other purpose set forth in the space below (if for the Client's own purpose, please write "At request of Client"):

_____.

4. Research Related Requests. If the purpose of this Authorization is for use and/or disclosure of health information for a research study conducted by or in which YCS participates and I refuse to sign this Authorization, then the Client will not be permitted to participate in the research study and YCS reserves the right to deny treatment associated with such research study, but this refusal will not affect any other treatment or health care for the Client.

5. Certain Third Party Requests. If this Authorization is being requested by YCS in order to release health information that would be created or obtained in connection with a third party's request for an evaluation or examination, such as a request by a life insurer, and that third party's agreement to pay for such evaluation/examination is conditioned on the release of such information, and I refuse to sign this authorization, I understand that YCS may refuse such evaluation or examination unless and until services are paid in full.

6. Marketing Purposes. If this Authorization is requested by YCS so that it may use health information in connection with marketing activities, YCS must indicate whether it is receiving compensation or anything of value for its disclosure of the health information. Unless otherwise indicated below, YCS is not receiving anything of value for its disclosure of health information in connection with marketing activities.

_____ YCS ***is*** receiving something of value for its disclosure of health information in connection with marketing activities.

7. Client's Right to a Copy of Authorization and Information Released. I understand that I am entitled to receive a copy of this Authorization from YCS. In addition, in accordance with regulations of the New Jersey Department of Human Services, the Client or other person authorizing the disclosure of mental health records has the right to inspect the material to be disclosed, unless the Client's treating clinician certifies to YCS's President or Executive Vice President that the disclosure of the Client's clinical mental health records to the Client him/herself would be reasonably likely to be seriously harmful to the Client's treatment or health; a denial of access to mental health records for this reason shall be limited only to the extent necessary to protect the Client.

8. Right to Revoke Authorization. I understand that I may revoke this Authorization at any time by notifying YCS in writing at the address set forth at the top of this page (sent to the attention of YCS's Executive Vice President/COO). I understand that if YCS has already released information or otherwise acted in reliance upon this Authorization, any subsequent revocation will not affect the validity of YCS's prior disclosure or other prior action that had already been taken based on this Authorization. I also understand that if this Authorization was provided for purposes of obtaining insurance coverage, my revocation might give rise to the Insurer's right to contest a claim and/or to contest the validity of any insurance issued in reliance on the Authorization.

9. Expiration of Authorization. If not revoked by me sooner, I understand that this Authorization will expire on _____.

(*identify date of expiration or event that will trigger expiration of this Authorization*)

If the undersigned fails to specify an expiration date or an event that triggers expiration in the space above, I understand that this Authorization will expire four (4) months from the date of the undersigned's execution of this Authorization.

I have read and understand the terms of this Authorization and I hereby knowingly and voluntarily authorize YCS to disclose the Client's health and medical information and records in the manner described above. In addition, I have been provided a copy of this Authorization.

Print Client's name	*Signature of Client if: (a) Client is 18 years old or older; (b) Client is a minor who is 14 years old or older and voluntarily participating in a residential program of YCS; or (c) Client is a minor who otherwise meets the circumstances described in footnote 1 below* [1]

Dated:_____

If the Client is a minor (a person under 18 years of age) and does not qualify to sign this Authorization on his or her own under the circumstances described in footnote 1 below, then this Authorization must be signed by the Client's Legal Representative:

Print name of Legal Representative	*Signature of Legal Representative*
Dated:_____	*Print relationship of Legal Representative to Client and authority to act on behalf of Client*

[1] If the Client is a minor (i.e., a person under 18 years of age), then his or her parent, next of kin or legal guardian must sign this Authorization on behalf of the minor, subject to the following exceptions where a minor may sign the Authorization on his or her own:

• The minor is pregnant. • The minor is married. • The minor is emancipated (as determined by a court). • The minor is being treated for drug and/or alcohol abuse. • The minor is age 13 or older and is being treated for a sexually transmitted disease. • The minor is age 13 or older and is being treated for AIDS or HIV. • The minor is age 14 or older and voluntarily participating in residential treatment for mental health services from a provider licensed by the New Jersey Department of Human Services. • The minor is age 16 or older and participating in temporary outpatient behavioral health care services for mental/emotional health issues from a New Jersey licensed health care provider or licensed outpatient health care facility.