



Juvenile Justice – Behavioral Health

Multiple-Party Consent for Release of Information

Medicaid /Other Insurance #: _____
Medical Record #: _____
NC-JOIN #: _____

Juvenile’s Full Name: _____ DOB: _____
Parent, Guardian, or Custodian: _____ County: _____

I authorize the NC Department of Public Safety, Juvenile Justice (hereinafter, “JJ”) and the following parties:

(1) Mental Health, Developmental Disabilities, or Substance Abuse Services Provider

Name: _____
Address: _____
Phone: _____

(3) Agency to facilitate multi-system coordination

Name: _____
Address: _____
Phone: _____

(5) Other

Name: _____
Address: _____
Phone: _____

(2) Local Management Entity/Managed Care Organization (if necessary to authorize services)

Name: _____
Address: _____
Phone: _____

(4) Other

Name: _____
Address: _____
Phone: _____

(6) Other

Name: _____
Address: _____
Phone: _____

To communicate with and disclose to one another the following information relating to the juvenile named above.

Table with 2 columns: INFORMATION TO BE SHARED: (1-10) and (11-15). Includes a note: 'I authorize all of the foregoing information to be shared unless I indicate here, by number, one or more categories of information not to be shared:'



	PURPOSE OF USE AND DISCLOSURE	
--	--------------------------------------	--

The purposes for the disclosures authorized by this form are:

1. To assess the juvenile's need for mental health, developmental disabilities, or substance abuse services (hereinafter, "MH, DD, SA services").
2. To provide, manage, and coordinate JJ and MH, DD, SA services for the juvenile.
3. To develop a Person Centered Plan, Service Plan, and/or Treatment Plan for the juvenile.
4. To make dispositional recommendations for a court-involved juvenile.
5. To establish financial assistance or other payment for services.
6. To assess the quality and effectiveness of JJ and MH, DD, SA services.
7. To improve service and treatment outcomes for juveniles involved in the JJ and MH, DD, SA services systems.
8. Other (please specify): _____

	REVOCAION AND EXPIRATION	
--	---------------------------------	--

I understand that I have the right to revoke this authorization at any time except to the extent that a person or agency which is to make a disclosure has already taken action in reliance on it. If I want to revoke this authorization, I may sign the ACT TO REVOKE section attached to this form and submit it to one of the agencies named above. In addition, authorization for an MH, DD, SA services provider to disclose information may be revoked by following the procedures described in that provider's Notice of Privacy Practices. If not revoked sooner, this authorization expires automatically upon the termination of either JJ involvement or juvenile court jurisdiction, or one year from the date it is signed, whichever is earlier. Authorization to disclose information for the purpose of continuing established financial benefits will be considered valid until the cessation of benefits.

	REDISCLASURE AND CONFIDENTIALITY	
--	---	--

Once health care information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing information to others. However, mental health, developmental disabilities, and substance abuse information protected by state law (G.S. 122C), as well as substance abuse treatment information protected by federal law (42 C.F.R. Part 2), remain confidential and must not be redisclosed by the recipient except as authorized by those laws or this authorization.

	NOTICE OF VOLUNTARINESS	
--	--------------------------------	--

I understand that I have the legal right to refuse to sign this authorization form. If I choose not to sign this form, I understand that healthcare providers and health plans cannot deny or refuse to provide treatment, payment for treatment, enrollment in a health plan, or eligibility for health plan benefits because of my refusal to sign.



SIGNATURES	
Signature of Juvenile: _____ Print Juvenile Name: _____ I have the right to have a signed copy of this form.	Date: _____
Signature of Parent, Guardian, or Custodian: _____ Print Parent/Guardian/ Custodian Name: _____ Describe authority to act on behalf of juvenile (check a box or offer other explanation): <input type="checkbox"/> I am the juvenile's parent <input type="checkbox"/> I am the juvenile's guardian <input type="checkbox"/> I am the juvenile's legal custodian Other: _____ I have the right to have a signed copy of this form.	Date: _____ Date: _____
Signature of staff witnessing the signatures above: _____ Print Staff Name: _____	Date: _____
ACTION TO REVOKE	

A. WRITTEN REVOCATION (use either 1 or 2 below, not both)

1. I am revoking the entire authorization:

I hereby give notice that the authorization to disclose information relating to _____
Print name of juvenile

signed by me _____ on _____ is revoked, effective _____.
Print name of person who signed authorization Date of authorization Date

Signature of person who is revoking authorization Date

OR



2. I am revoking the authority of the parties named below to disclose and receive information:

I hereby give notice that the authorization to disclose information relating to _____
Print name of juvenile

signed by me _____ on _____ is revoked, effective _____
Print name of person who signed authorization Date of authorization Date

only with respect to the party or parties named below. The authorization remains in effect for other parties named in the authorization.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Authority of _____ to disclose and receive information is revoked.

Signature of person who is revoking authorization Date

Signature of Staff witnessing the revocation Date

B. VERBAL REVOCATION

I, _____, attest that a verbal declaration was made on
Print name of staff receiving revocation

_____ by _____ to revoke this authorization
Date of verbal revocation Print name of person revoking authorization

to disclose information relating to _____.
Print name of juvenile

Signature of staff receiving revocation Date