AUTHORIZATION FOR THE DEPARTMENT OF JUVENILE JUSTICE (DJJ) TO RELEASE INFORMATION FOR TREATMENT OR SERVICES

Client's Full Name: _____ ***DOB:*** _____

The Virginia Department of Juvenile Justice (DJJ) partners with other entities to better meet the needs of our youth through treatment and programming. These entities are also committed to protecting your personal information throughout this process and we want to make sure that DJJ and these entities only share your protected information when authorized by law.

☐ I hereby authorize the Virginia Department of Juvenile Justice (DJJ) and its contracted entities to share my confidential information with the following entities/individuals for the purposes of compliance monitoring, service coordination & treatment planning, eligibility determination, utilization review, and the procurement of services. Information may be shared in the form of written information, computerized data, in person, or by phone.

Authorized Recipients: *(Indicate which entities/individuals may receive confidential information)*

☐ Behavioral Health & Developmental Services (DBHDS)
☐ Community Services Board (CSB)
☐ Children's Services Act (CSA) Coordinator
☐ Department of Social Services (DSS)
☐ Department of Corrections (DOC)
☐ Magellan or Other PPO/HMO: _____
☐ Providers subcontracted with Evidence-Based Associates (EBA) and AMIkids (AMI)
☐ Providers coordinated through local VJCCCA offices
☐ Health Care Providers
☐ Department of Education, local school system, and post-secondary programs _____
☐ Tidewater Youth Services Commission
☐ Others: _____

Confidential Information: *(Check "All Available Records" or indicate individual types of information you consent to share)*

☐ **ALL AVAILABLE RECORDS (this includes substance use disorder and education information)**

☐ Assessment Information
☐ Benefits / Services Needed
☐ Criminal Justice Records
☐ Educational Records
☐ Financial Information
☐ Mental Health Diagnosis
☐ Planned/Received Treatment
☐ Psychological Records
☐ Psychiatric Records
☐ Medical Diagnosis / Records
☐ Infectious Diseases (includes sexually transmitted diseases)
☐ Family Planning
☐ Substance Abuse Screenings/ Drug Tests/Assessments
☐ Other: _____

Right to List of Recipients and Expiration or Rescission of Consent

I can request a list of the specific entities/individuals to which/whom my information has been disclosed at any time, by submitting a written request to DJJ or its contracted entities. This authorization may be revoked at any time, except to the extent that DJJ or the contracted entity has already acted in reliance on it (for example, if the information has already been shared). To revoke this authorization, I must do so in writing to DJJ or its contracted entities. Unless otherwise revoked, this authorization will expire one year from the date signed or within 30 days of my case being closed to the Department of Juvenile Justice, whichever comes later.

Client Signature: According to § 54.1-2969(E) of the Code of Virginia, a person under 18 (minor) is considered an adult for the purpose of disclosing medical records covering medical or health services for infectious diseases (including venereal diseases), family planning, substance abuse, and mental illness. The minor's consent is required in order to release these records, unless otherwise permitted by a court order or applicable law.

Voluntary Signing: I understand that authorizing the disclosure of this confidential information is voluntary. I can refuse to sign. I understand that confidential information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient; however, the recipient may be prohibited from re-disclosing substance abuse information.

I have carefully read (or had read to me) and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information to entities/individuals listed above.

Client's Signature: _____ **Date:**_____
(Required for clients 18 or older as well as for clients consenting to release of certain information as outlined above.)

Authorized Signature: _____ **Date:** _____

Relationship to client: ☐ Self (client over 18) ☐ Parent ☐ Guardian ☐ Other (List) _____

SUBSTANCE USE DISORDER RECORDS

The information obtained by this release may be disclosed from records protected by federal confidentiality rules (42 CFR PART 2). FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.