JEFFERSON COUNTY COLORADO | Human Services
*Steps to a better, safer life*

**Division of Children, Youth, Families, and Adult Protection**
**Authorization for Release of Information (ROI)**

I, ______________________________________(Print Name), __________________ (date of birth) agree to release of the following information TO and FROM the Jefferson County Department of Human Services, Division of Children, Youth, Families, and Adult Protection Services and the following sources:

**Provider/Agency:** ____________________________________________________________

**Individual(s) for whom information will be released:**

☐ Self

☐ Other ______________________________________________________________

**Information to be released:**

☐ All records, medical and mental health records, including drug/alcohol diagnosis, treatment or referral information

☐ Other (specify): ____________________________________________________________

I authorize use of this information only for the purpose of acquisition, provision, oversight, referral for services and support of appropriate child welfare services, mental health evaluation or treatment, medical evaluation and treatment, rehabilitative treatment including speech and language, physical, and occupational therapy, dental evaluation or treatment, substance abuse evaluation or treatment, and educational services for the adult(s) or child(ren) named above.

I understand if I fail to sign this authorization, Jefferson County Department of Human Services may not provide services or make referrals for services of the types mentioned and may seek or be subject to court-ordered disclosure of the requested information as may be allowed by law.

I understand that that there is the potential for re-disclosure by the recipient and that it may no longer be protected by the HIPAA Privacy Regulation. I also understand that all information provided pursuant to this disclosure may be subject to re-disclosure, on a need to know basis pursuant to C.R.S. § 19-1-303 and § 19-1-307, to the relevant out of home placement provider, treatment services provider, County Attorney's Office, and to the courts of the State of Colorado, CASA program, counsel for respondent parents, guardians and legal custodians, as well as to Guardians *ad Litem* or their agents.

This authorization will expire within 180 days after the end of treatment. This authorization may be revoked earlier in writing if the entity providing the information has not yet disclosed information in reliance on it. Written revocation must be provided to the Child Welfare Program Administrator at Jefferson County Department of Human Services, 900 Jefferson County Parkway, Golden CO 80401.

(continued on next page)

**NOTIFICATION OF STUDENT INFORMATION SHARING (if applicable)**
Student information is being collected and shared between Jeffco Schools, Jefferson County Human Services, and program partners for the purpose of improving educational outcomes for all children/youth. This information will include and is not limited to grades, attendance, behavior and credit accumulation. You may be contacted by a staff member at the Student Engagement Office regarding additional services and resources for your student. If you would like more information, please contact Addi Cantor with Jeffco Schools at (303) 982-6401.

**AUTHORIZATION FOR THE RELEASE OF INFORMATION CONCERNING THE DIAGNOSIS, EVALUATION, OR TREATMENT OF DRUG OR ALCOHOL ABUSE (if applicable)**
I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 And the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), 45 C.F.R. Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties.

**PROHIBITION ON REDISCLOSURE (if applicable)**
This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the authorization of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**AUTHORIZATION**

| ________________________________ | __________________________ |
|---|---|
| Signature | Date Signed |

---------------------------------------------------------------------------------------------------------------

**REVOCATION**
To be completed only when authorization for release of information is being revoked.

| ________________________________ | __________________________ |
|---|---|
| Signature and Date of Revocation | Witness/Agency and Date |