



# Consent for Release to parent/Guardian/Involved Individual

I, \_\_\_\_\_, \_\_\_\_\_, authorize the Juvenile Rehabilitation  
 YOUTH'S NAME DATE OF BIRTH

Administration (JRA) to release to \_\_\_\_\_ the following information:  
 NAME RELATIONSHIP

NUMBER SHOWN INDICATES AGE REQUIRED FOR CONSENT.  
 YOUTH AT OR ABOVE THE AGE OF CONSENT MUST INITIAL ALL THOSE CATEGORIES THEY WISH TO RELEASE.

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|--|---|
| _____ Client History Review (18)               | _____ HIV/AIDS testing/treatment records (14)                     |
| _____ Family/social history (18)               | _____ Sexually Transmitted Disease testing/treatment records (14) |
| _____ General medical care/dental records (18) | _____ Drug and alcohol evaluation/treatment records (13)          |
| _____ Polygraph examination (18)               | _____ Mental health records (13)                                  |
| _____ School education records (18)            | _____ Psychosexual Evaluation (13)                                |
| _____ Treatment reports/discharge reports (18) | _____ Birth control/abortion services records (any age)           |

I understand my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 which states: **“This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part 2. The federal rule prohibits you from making any further disclosure of this information (unless further disclosure is expressly permitted by written consent 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. The federal rules restrict any use of the information to criminally prosecute any alcohol or drug abuse patient.”** Records are also protected by State law and regulations and JRA policies. I understand any records that contain information regarding HIV/confirmed STD tests or treatment are protected by state confidentiality laws.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I understand these records may be provided in various forms (e.g. computer data transfer, mail, Fax, hand delivery, or verbally).

I understand the release authorized is for the purpose of sharing information with my parent or guardian or involved individual.

I understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it and in any event, this consent expires automatically 90 days from signature date per RCW 70.02.030.

YOUTH/CLIENT'S SIGNATURE	DATE	WITNESS'S SIGNATURE	DATE
<b>REAUTHORIZATION</b>			
YOUTH/CLIENT'S SIGNATURE	DATE	WITNESS'S SIGNATURE	DATE
YOUTH/CLIENT'S SIGNATURE	DATE	WITNESS'S SIGNATURE	DATE
YOUTH/CLIENT'S SIGNATURE	DATE	WITNESS'S SIGNATURE	DATE
YOUTH/CLIENT'S SIGNATURE	DATE	WITNESS'S SIGNATURE	DATE
This consent for release is revoked effective (date)		YOUTH/CLIENT'S SIGNATURE	DATE

Original to Case File