

**THIRTEENTH JUDICIAL CIRCUIT COURT
FAMILY COURT
Juvenile Division**



**AUTHORIZATION FOR RELEASE OF SCHOOL INFORMATION, MEDICAL INFORMATION
AND/OR INDIVIDUAL ACCESS TO INFORMATION PURSUANT TO HIPAA (HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT), 45 C.F.R. PARTS 160, 164 and 42 C.F.R. Part 2**

TO: _____

RE: Name: _____

DOB: _____

This release will authorize the Boone and Callaway County Juvenile Officer and Robert L. Perry Juvenile Justice Center Personnel, or any representative of the office, to inspect and copy the above named individual's school records, and/or protected health information (PHI), as set out below and for you to mail such information to:

- Boone County Juvenile Office, 705 East Walnut, Columbia, Missouri 65201
Telephone # (573) 886-4200, Facsimile # (573) 886-4030
- Callaway County Juvenile Office, 2800 Cardinal Drive, Suite A, Fulton, Missouri 65251,
Telephone # (573) 642-7992, Facsimile # (573) 642-6036
- Robert L. Perry Juvenile Justice Center, 5665 N. Roger Wilson Drive, Columbia, Missouri 65202,
Telephone # (573) 886-4450

Purpose of Request: Review of records in relation to a juvenile court matter pertaining to abuse/neglect allegations and/or delinquency allegations

INFORMATION TO BE DISCLOSED:

- Complete school record including, but not limited to; attendance, disciplinary/performance reports, SWISS reports, Individual Education Plan, 504 Plan, standardized testing reports
- Complete medical record including, but not limited to; records from other facilities (including secondary release records), admission and disclosure summaries, nurses notes and assessments, testing reports, physician progress notes (clinic/office records), ER records, history and physical examinations, and/or any additional documentation regarding the above named individual.
- Complete mental health records including, but not limited to; intake sheets, records from other facilities (including secondary release records), admission and disclosure summaries, psychological/psychiatric/clinician progress notes (clinic/office records), history examinations, and/or any additional documentation regarding the above named individual.

Complete substance abuse records including, but not limited to; intake sheets, referral documents, records from other facilities (including secondary release records), admission and disclosure summaries, testing reports, psychological/psychiatric/clinician progress notes (clinic/office records), history examinations, and/or any additional documentation regarding the above named individual.

I UNDERSTAND THAT:

1. This request is voluntary on my part. I may refuse to sign this authorization.
2. I have a right to revoke this authorization at any time, except to the extent that prior action has been taken in reliance on this authorization. I understand if I want to revoke this authorization I must mail, fax or bring a letter in person stating I want to revoke this authorization to the address or facsimile number noted at the top of this authorization.
3. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
within one (1) year from the date signed.
4. Once the information has been released pursuant to this authorization, it may no longer be protected by Federal and/or State regulation and may no longer be deemed "Confidential". Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA and its implementing regulations. The federal rule, 42 C.F.R. 42, Part 2 specifically pertaining to substance abuse treatment records prohibits further disclosure of this information to other persons, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. The information will not be used for criminal investigative purposes or for prosecution of drug or alcohol related offenses.
5. A photocopy of this authorization is as valid as the original.
6. I may inspect or copy the information to be used or disclosed, as provided in Federal and/or State regulation and as provided in C.F.R. 164.524. I understand that I have a right to a signed copy of this authorization upon request.

Signature: _____

Date: _____

Print Name

Relationship to Individual

Signature of Juvenile Officer or representative: _____