

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

This child is referred for admission to **GRAFTON**, a residential/educational program for youth between the ages of 5 and 21.

CLIENT NAME: _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____

I, _____, give my consent for _____ (Facility or Person) to release information.

To: **GRAFTON**
ADMISSIONS DEPARTMENT
 P.O. Box 2500
 Winchester, VA 22604

FAX: 540-542-1721

The requested data shall include:

	Treatment Information		School Information		Medical Information
<input type="checkbox"/>	Treatment Plans	<input type="checkbox"/>	Current IEP	<input type="checkbox"/>	Physical/Medical History
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Educational Evaluation	<input type="checkbox"/>	Dental Screening
<input type="checkbox"/>	Psychological Report	<input type="checkbox"/>	Speech Evaluation	<input type="checkbox"/>	Immunization Records
<input type="checkbox"/>	Psychiatric Report	<input type="checkbox"/>	Occupational Therapy Evaluation	<input type="checkbox"/>	Medication Reviews
<input type="checkbox"/>	Social History	<input type="checkbox"/>	Physical Therapy Evaluation	<input type="checkbox"/>	Results of Recent Medical Tests
<input type="checkbox"/>	Behavior Plans	<input type="checkbox"/>	Educational Transcripts	<input type="checkbox"/>	Medication/Supplement List
<input type="checkbox"/>	History of Therapeutic Passes	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

I was informed of the information requested and the benefits of its release. I further understand that the provision of services is contingent on the release of this information. This authorization will expire in one year from date of signature.

 Signature of client (If 12 years or older)

 Date

 Signature of Parent or Guardian (if patient under 18 years, not emancipated and not seeking substance abuse treatment)

 Date

 Signature of Witness

 Date

This release is confidential and is protected by Federal Law. FEDERAL REGULATIONS 42 (CFR Part 2): ALCOHOL & DRUG: The medical records are protected under the federal regulation governing confidentiality of alcohol and drug abuse and cannot be disclosed without written consent unless otherwise provided for in the regulations. The federal rules restrict any use of this information for the criminal investigation or prosecution of any alcohol or drug abuse patients. HIV/AIDS: Under Virginia Law, confidential HIV testing or treatment information can only be given to persons authorized by you by signing a release, or to those authorized by law to receive this information without your consent. I understand that I do not have to release HIV related information, and that I can change my mind at any time.

Revoked Date _____ Reason _____

Signature _____ Staff _____