Simply Hope Safe Teen Assessment Center
1323 Oakley Ave. Suite 20
(208) 679-9401

RELEASE OF INFORMATION

Name: ____ Phone: ____
DOB: ____ SSN (optional): ______________________________________
Address: ____

Part I: Identification of Entities and Information

I hereby authorize Simply Hope Safe Teen Assessment Center (STAC) to exchange: ☒ release ☒ receive my health and related information with the following entity: **(Please check the box AND initial next to all that apply.)**

FROM	TO
Counseling Referral	**Simply Hope Safe Teen Assessment Center**
Name: __________________________________	1223 Oakley Ave Suite 22
Address: ________________________________	Burley, ID 83318
____	208-650-4126
Phone: __________________________________	Requested by: ____________________________

I authorize the following information to be exchanged [released and/or received] among the entities listed above:

Type of Information to be released OR obtained: (Please initial next to checked items)

☒ Diagnostic Assessment	☒ Assessment Summaries	☐ Prognosis
☒ Progress in Treatment	☐ Laboratory Results	☐ Screening Results
☒ Attendance	☒ Treatment Plans	☒ Social/Family History
☒ Progress Notes	☒ Discharge Summary	☐ Legal Records
☒ Psychological Eval	☒ Physiological Testing Results	☐ School Records/Behavioral Observations
☒ Recommendations		

☐ Other: ____

The following information is exempt/excluded from this release: ____
____

Unless otherwise indicated, the information released may include records from other providers that are included in the listed entities records.

Purpose and Intended Use of Disclosure/Exchange of Records: (Check all that apply)

☐ Participation in Teen Hope ☒ Continuity of Care ☒ Evaluation ☒ Treatment

☐ Other: ____

Part II: Revocation Statements

This Authorization for Release of Confidential Information is effective from the date of signature until the following date, event, or condition: ____

However, I understand that I may revoke this Authorization at any time by delivering written notice to the primary clinical provider indicated in Part I of this document, except to the extent that any of the listed entities have taken action in reliance on the Authorization prior to my notice of revocation. Further, I understand this authorization is effective for the above timeframe but **cannot exceed one year from the date of signature.**

I understand that my refusal to sign this Authorization will prevent my participation in some programs and will prevent potentially vital communication between providers if I am involved in multiple service systems.

Youth Signature ____ Date ___________________________
Parent/Guardian Signature: ___________________________________ Date ___________________________
Relationship to Youth: ____

Staff Witness Signature ______________________________________ Date ___________________________