Authorization for Release of Information

I, ____________________________ (name of client), in accordance with federal rules, 45 CFR part 164 (Health Insurance Portability and Accountability Act of 1996), authorize the release of information about me as indicated below and hereby consent to communication between Evolution Youth Services and the following:

☐ Denver Public Safety Youth Programs
☐ Juvenile Probation
☐ Denver Probation
☐ Denver Police Department
☐ Parent
☐ Denver Public Schools
☐ Denver County Court Probation
☐ GRID
☐ Denver Sheriff’s Department
☐ Department of Human Services
☐ ____________________________

The purpose of and need for the disclosure is to inform agencies indicated above of my attendance, behaviors, performance, coordination of services and progress in my treatment.

The extent of information to be disclosed is:

| ☐ Name | ☐ Diagnosis Information | ☐ Pre-Sentence Report |
| ☐ Referral Information | ☐ Attendance Data | ☐ Other |
| ☐ Clinical Progress Data | ☐ Clinical Termination Data | ☐ Other |

I understand that this release of information will remain in effect for a period of one year.
I understand that I may revoke this consent at any time through written notification and upon confirmed receipt by Evolution Youth Services.

I hereby give permission to the Denver Public Schools, the City and County of Denver, and other partner organizations to release educational records (including but not limited to attendance record, grades, test scores, behavioral referrals, suspension/expulsion records and/or delinquency/criminal and other records to Evolution Youth Services for the purposes of evaluating the success of the program and to be able to more effectively serve my child. I also give permission for my child to respond to questions that assess my child’s experience with Evolution Youth Services, his/her feedback on the program, and any impact the program may have had on my child’s academic performance and/or behavior. I understand that all information collected on my child will be kept confidential as required by applicable law, and that these confidential records will not be used for any purpose other than to evaluate the success of the program. Data will be released to authorized outside entities for evaluation purposes and all confidentiality standards will be upheld.

Authorization

My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including a fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

Youth’s Signature: ____________________________ Date: ________________
Printed Name of Parent/Guardian: ____________________________
Signature of Parent or Guardian: ____________________________ Date: ________________
Relationship to Youth: ____________________________
Evolution Youth Staff Name: ____________________________ Date: ________________
Evolution Youth Staff Signature: ____________________________