TEENHOPE
Mental Health Teen-Screening Programs

AUTHORIZATION TO USE OR DISCLOSE INFORMATION FOR STUDENTS

Please read and complete all items

Student Name: _____

I give permission for the information described below to be gotten from or given to (mark all that apply and specify name and relationship):

School Counselor (name of counselor and school): _____

Parent/Guardian (name and relationship): _____

Other (Specify name and relationship): _____

The information I give permission to be given to _____(same as above) is:

Information about my TeenHope screening

For the purpose of:

Support and guidance of my school counselor

I understand that the information in my health record will include information about behavioral or mental health services.

I understand that if the use/disclosure of these records is for my own use, I will receive either a copy or a summary of my health information within 30 days of my request and that I may be charged a reasonable, cost-based fee.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

I understand I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires one year after the date of execution, whichever comes first.

I understand that my printed name in the signature space serves as my signature for this document.

Name of student: _____

Signature of student: _____

Date: _____