



Consent for Release of Information

Client Name: _____ Birth Date: _____

Address: _____

Phone: _____ Parent Email: _____

I authorize Reach For Youth to release/obtain the following information

- Psychological
- School/Education information
- Legal information
- Substance Abuse & Treatment information
- Communicable Disease & HIV information
- Medical History/information
- Other (specify) _____

Please explain the purpose of this release:
To facilitate participation in Reach For Youth's programs.

Please release/obtain records to/from the following person/agency:

Agency: _____ Phone Number: _____

Address: _____

Contact Person: _____ Email: _____

MY RIGHTS: I understand I have a right to confidentiality and as such any information to which Reach For Youth is privy. I understand that this release is effective for one (1) year from the date of my signature unless I request in writing that the release be withdrawn. Request to withdraw consent must be in writing; please contact the Clinical Supervisor at Reach For Youth with any questions/concerns at 317-920-5900.

Client Printed Name	Date
Client Signature (If 18)	Date
Parent/Guardian Signature (if minor)	Date
Probation Officer/ Official	Date

REACH FOR YOUTH, Inc

Prohibition on Re-Disclosing Information Concerning AOD Abuse Treatment Clients

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment made to you with the consent of such client. This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.



Referral

REFERRAL SOURCE (Referring Agency/School Contact)

Name: _____

Title: _____

Phone: _____

Email: _____

Preferred contact method:
Referring Agency/School
Name:

IDENTIFYING INFORMATIONYouth's Name: _____ Gender: Male Female DOB: _____ Grade: _____

Parent/Legal Guardian: _____

Current Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Special Education Services: No Yes

REASON FOR REFERRAL *Describe the incident that resulted in referral:*

PRESENTING PROBLEMS (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Suspected Alcohol or Drug Abuse | <input type="checkbox"/> Suspected Theft and/or Vandalism | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Disorderly Conduct | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Academic Failure |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Depressive Symptoms |
| <input type="checkbox"/> Temper Outbursts | <input type="checkbox"/> Fighting/Assaultive | <input type="checkbox"/> Peer Problems |
| <input type="checkbox"/> Truancy and Attendance Problems | <input type="checkbox"/> Refusal to Follow Teacher/School Instructions | |

Preferred Program for youth to attend: Mental Health Counseling R.E.A.C.H.
 Workshop (Theft/Conflict Resolution) Restorative Justice
 Teen Court

Does youth have a history of problems in other domains? Personal Life/Home History of Juvenile Probation Department History of DCS involvement