DIVISION OF CHILD AND FAMILY SERVICES (DCFS)
Children's Mental Health Programs
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME (Print):____________________________________ **MEDICAL RECORD #:** _____________

DATE OF BIRTH: ____
(MM/DD/YYYY Format)

Information Requested From:

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Information Released To:

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- ☐ Discharge Summary
- ☐ History & Physical Exams
- ☐ Psychiatric Evaluations
- ☐ Consultation Reports
- ☐ 90 Day Reviews
- ☐ Aftercare Plan
- ☐ Medication Records
- ☐ Physician's Orders
- ☐ Diagnosis
- ☐ Psychological Evaluations
- ☐ Care Coordination Plans
- ☐ Lab/X-ray Reports
- ☐ Children's Uniform Mental Health Assessment
- ☐ Targeted Case Management Assessment
- ☐ Strengths, Needs, & Cultural Discovery
- ☐ Medicaid Authorization Documentation
- ☐ Treatment/Rehabilitative Plans
- ☐ Other (specify):

For the purpose of:____

It is the policy of DCFS to release only that information about a client/patient or a former client/patient, as required by law is meets the "minimum necessary" rule; i.e., DCFS will not release more information than is needed to satisfy the request for information. Federal Regulations, Nevada Statutes, and/or Administrative Regulations protect medical records and any further disclosure is prohibited without the consent of the undersigned. Executing an authorization to release confidential information in no way binds DCFS to open its records for inspection, or to otherwise provide information which may violate the DCFS policy or applicable laws.

This authorization to release confidential information from Medical Record #_____________ is effective upon the date of execution. This authorization is subject to written revocation at any time, except to the extent that action has already been taken in reliance thereon. If this authorization is revoked, it will not cause a penalty or denial of services with the exception of # 2 and # 3 below. This authorization is valid for one year from the date of execution unless revoked prior to one year.

ACKNOWLEDGEMENTS for AUTHORIZATION TO RELEASE INFORMATION

1. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under # 2 and # 3 of these acknowledgements for authorization to release information.
2. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, DCFS reserves the right to deny treatment associated with such research.
3. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization DCFS reserves the right to deny that health care.
4. I understand that I may revoke this authorization at any time by notifying DCFS in writing, except to the extent that: (a) information has already been released based on this signed authorization; or, (b) if authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
5. I understand that information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal Protected Health Information rules and regulations.
6. I understand that I may inspect and/or request a copy the information used or released by the execution of this authorization.
7. I release DCFS and any employee of DCFS from any liability arising from my request for the release of information to the person/agency designated above.

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☐ Legally Responsible Person (Print) ***OR*** ☐ Client, at age of majority or if legally emancipated (Print)	Legally Responsible Person Signature ***OR*** Client Signature	Date

DCFS Staff Witness Name and Title (Print)	Witness Signature	Date