State of Oklahoma
OFFICE OF JUVENILE AFFAIRS

Authorization To Release Juvenile Information

Name	Date of Birth	Social Security Number

COMPLETE THIS SECTION IF INIDIVIDUAL IS OVER THE AGE OF 18.

I, _____, give permission for the Office of Juvenile Affairs to release my records described below to: _____, for the specific time frame of _____ to _____, for the following purpose: _____.

COMPLETE THIS SECTION IF JUVENILE IS UNDER THE AGE OF 18.

I, _____, parent / guardian / personal representative / attorney, of _____, a juvenile under the age of 18 years, give permission for the Office of Juvenile Affairs to release his/her records described below to: Wesleyan Youth, Inc., for the specific time frame of _____ to _____, for the following purpose background check for foster family.

By initialing the spaces below, I specifically give permission to release the following records:

___ Sexually Transmitted Disease	___ Dental Records	___ Master Treatment Plan and Updates
___ HIV/AIDS Related Information	___ Mental Health Records, including Psychological /Neuropsychological Records and Reports	___ Educational Records and Assessments, including IEP, if available
___ Medical History, Reports, Immunizations and Summaries		X JOLTS summary
___ X-Rays and Diagnostic Reports		
___ Genetic Testing and Records	___ Psychosocial History	___ OTHER (Describe: _____
___ Prescription Medications and Psychotropic Medications	___ Doctor and Nurses Notes	_____
___ Drug/Alcohol Abuse Information	___ Hospital Records and Pathology Reports	_____
___ Substance Abuse Treatment	___ Criminal and Case Histories and Court Records	_____

I understand that the information authorized above for release may include what may be considered information about a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immune-deficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS). I understand that the information concerning a communicable or venereal disease is made confidential by law and cannot be released without specific permission except in limited circumstances, including release to the persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among healthcare providers, or release for statistical or epidemiological purposes. When such information is released, it cannot contain identifying information unless release of the identifying information is authorized by me, by an order of the court, or by the Department of Health, by law.

I understand that the person or organization who receives the health information requested may not be covered by federal and state privacy regulations or laws, and such protected health information may be re-disclosed and no longer protected by those regulations. I also understand that I do not have to sign this form. If I do not sign this form, it may prevent treatment or any other required eligible services from the Office of Juvenile Affairs. I understand that I can look at a copy of the information released under this Authorization.

I understand that I may revoke permission to release information. If I want to do this, it must be in writing. I understand that I cannot revoke permission for information that has already been released. Unless I revoke permission sooner, this Authorization will expire in 180 days or _____.

I hereby waive and release any rights and claims I have or may have against the Office of Juvenile Affairs or its Board members, officers, directors, employees, agents and servants, including but not limited to, medical and nursing personnel, of and from any and all liability whatsoever arising out of or resulting from the disclosure of the information requested to be released.

Signature of Person Requesting Release	Print Name	Date