Exchange of Information

Idaho Youth Suicide Prevention Program

Ensure that the parents/guardians understand their rights to confidentiality and the benefits of sharing information before signing this document.

# Authorization for Exchange of Information

I, the parent/legal guardian of [First and Last Name of Client], authorize [Organization/Person] to disclose to and/or obtain relevant information from [Person or Organization]. The purpose of this disclosure of information is to improve treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services.

I understand that I have a right to revoke this authorization at any time by sending written notification to [Contact Name] at [Contact Information].

Unless sooner revoked, this authorization expires in one year on the following date: [date].

I agree to allow disclosure in any manner that is appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically. I will be given a copy of this authorization for my records.

|  |  |
| --- | --- |
| Parent/Guardian Signature |  |
| **Date** |  |
| **Staff Witness Signature** |  |
| **Date** |  |

Check below if applicable.

|  |  |
| --- | --- |
| Parent/guardian refused the exchange of information. |  |
| **Parent/guardian received a copy of this document.** |  |