SAMPLE
FLORIDA DEPARTMENT OF JUVENILE JUSTICE

Youth's Name _____

Date of Birth_____

JJIS Number_____

YOUTH CONSENT FOR RELEASE OF SUBSTANCE ABUSE TREATMENT RECORDS

I, _____ hereby consent to communication and
(Name of Client/Youth)

sharing of clinical records between _____
(Substance Abuse Service Provider)

and the Department of Juvenile Justice (DJJ) and _____
(DJJ Facility/Program)

The purpose of and need for the disclosure is to inform the Department of Juvenile Justice and the DJJ facility/program listed above of my progress in treatment. The information to be disclosed are records which describe my diagnosis and the extent of my substance abuse or dependence, information about my cooperation with the treatment program, prognosis and expected duration of my treatment.

I understand that my substance abuse treatment records are protected by State and Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise provided for by law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further understand that this consent will automatically expire when I am no longer in the custody of the Department of Juvenile Justice.

_____ _____
(Signature of Client/Youth) (Date)

_____ _____
(Signature of Designated DJJ Staff Member) (Date)

_____ _____
(Witness Signature) (Date)