

**CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)  
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_  
**Parent/Legal Guardian:** \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize  
(Client or Personal Representative)

\_\_\_\_\_ to disclose specific health information  
(Name of Agency)

from the records of the above named client to the representative of the following agencies serving as members of the local CASSP Service Team:

____ Division of Children & Family Services	____ Division of Behavioral Health Services
____ Division of Youth Services/Juvenile Services	____ Local School District
____ Arkansas Department of Health	____ Preschool or Head Start Program
____ Division of Developmental Disabilities Services/CMS	____ Other (please specify family member, agency or other provider) _____

The records may be sent to the CASSP Coordinator/Facilitator: \_\_\_\_\_  
(Name, Address, Phone, FAX)

for the specific purpose of determining eligibility for the CASSP process and to develop a Multi-Agency Plan of Service and monitor progress of services provided.

Specific information to be disclosed: \_\_\_\_\_

I understand that this authorization will expire on the following date, event or condition: \_\_\_\_\_

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose of providing treatment under the CASSP process, except for disclosures for financial transactions, wherein the authorization is valid for one year. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding. I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulation, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if the service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

_____ (Signature of Client or Parent/Legal Guardian)	_____ (Date)	_____ (Relationship/Authority)
_____ (Witness If Required)	_____ (Date)	

**REVOCATION SECTION**

I do hereby request that this authorization to disclose health information of \_\_\_\_\_

(Name of Client)  
signed by \_\_\_\_\_ be rescinded on \_\_\_\_\_  
(Name of Person Who Signed Authorization) (Date of Signature) (Effective Date)

I understand that any action taken on this authorization prior to the rescinded date is legally binding.

_____ (Signature of Client or Parent/Legal Guardian)	_____ (Date)	_____ (Relationship/Authority)	_____ (Witness If Required)
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NOTE: This authorization was revoked on (Date) \_\_\_\_\_ (Signature of CASSP Facilitator) \_\_\_\_\_

