



3501 DENALI STREET, SUITE 101
 ANCHORAGE, ALASKA 99503
 877.334.1314 TOLL FREE
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Instructions for Completing the Release of Information (ROI) Form

Note: As part of the Bring the Kids Home initiative, the Alaska Mental Health Trust Authority has funded a grant through the Department of Health and Social Services. This project was developed to target concerns of school districts in Alaska; students were arriving at their home school with minimal notice to the receiving school and lacking the necessary records from the schools they attended while in residential treatment.

Attached you will find our Release of Information (ROI) form. Once initialed and signed by the parent or legal guardian, this form will help us serve youth, families, schools, and treatment centers with the educational transition of youth back to Alaska.

Please take a moment to look over this form, and use the following directions to help you when needed:

Complete a separate ROI for EACH person, EACH school, and EACH treatment center

1. Name of Youth:	The youth who will be transitioning back to Alaska
2. Date of Birth:	The youth's birthday; mm/dd/year
3. Provider/Organization/School:	Name of the person, school, community service agency, or treatment center information may be exchanged with
4. Phone:	Area code and phone number for person, school, community service agency, or treatment center that information may be exchanged with
5. Address/City/State/Zip:	Mailing address of person, school, community service agency, or treatment center information may be exchanged with, if known
6. I am authorizing the following information to be exchanged verbally, written, and/or by facsimile:	Please initial next to each category that applies to indicate that you have read and agree
7. For the purpose of:	Please initial next to each category that applies to indicate that you have read and agree
8. This agreement will expire one year from the date of signature:	Please initial this section. The ROI is not valid until the parent or legal guardian initials this section.
9. Signature:	Sign, include phone number and date

Please note, to help ease the educational transition process of the youth it is useful to have access to all of the areas listed on the ROI.

Fax the completed Release of Information (ROI) form and any other important information to the attention of Amanda Riste at **907-569-0546**.



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Release of Information (ROI)

(Compliant with FERPA and HIPAA regulations)

Name of Youth: _____ Date of Birth: _____

I authorize the Provider/Organization/School/Agency listed below to exchange information and records with the Bring the Kids Home Educational Transition Support Project:

Complete a separate ROI for EACH person, EACH school, and EACH treatment center

 Provider/Organization/School Phone

 Address City/State/zip

Please initial next to each area that applies in each section. To help ease the educational transition process of the youth it is useful to have access to all of the areas listed below.

I am authorizing the following information to be exchanged verbally, written, and/or by facsimile:

- | | |
|---|---|
| <input type="checkbox"/> Name and identifying information | <input type="checkbox"/> Discharge / transition summary |
| <input type="checkbox"/> Educational records | <input type="checkbox"/> Continuing care plan and discharge recommendations |
| <input type="checkbox"/> School history information | <input type="checkbox"/> Attendance or dropout status in school |
| <input type="checkbox"/> Progress in treatment or continuing care | <input type="checkbox"/> Conduct in school |
| <input type="checkbox"/> Diagnostic summary | <input type="checkbox"/> Discharge date |
| <input type="checkbox"/> Medical records | |

For the purpose of:

- | | |
|--|---|
| <input type="checkbox"/> School/Teacher preparedness | <input type="checkbox"/> Parental participation |
| <input type="checkbox"/> On-going treatment or continuing care | <input type="checkbox"/> Other: _____ |

I understand that the information to be disclosed may include information pertaining to drug/alcohol abuse treatment, and rehabilitation or psychiatric treatment. I also understand that I may revoke this consent in writing at any time, except to the extent that the providing persons/organization set forth above have taken action in reliance on this authorization before receiving the written revocation. **This agreement will expire one year from the date of signature.** _____

(Please initial)

NOTE: This ROI is not valid until the parent or legal guardian initials this section.

 Parent or Legal Guardian Phone Date

 BTKH/Educational Transition Support Project Representative Phone Date