

Immediate Intervention Program Standards Kansas Department of Corrections- Division of Juvenile Services State of Kansas	CHAPTER: DOCUMENTATION, REPORTING AND RECORDS	STANDARD NO. IIP-03-103
	SUBJECT: SAFEGUARDING RECORDS AND DISCLOSURE	PAGE: 1 of 1
REFERENCES: None		DATE ADOPTED: 02-01-2017 DATE AMENDED: 02-01-2017 DATE REVIEWED: 12-31-2022

STANDARD: Written policy, procedure and practice shall require that youth records are safeguarded from unauthorized and improper disclosure. All youth information shall be maintained in a strict and confidential manner and an Authorization for Release of Confidential Information (Attachment A) is required prior to releasing any information. Immediate Intervention Programs (IIP's) shall deem all youth records confidential and shall not be disclosed except as provided by federal or state statute, by regulation or by court order.

DISCUSSION: Any medical information received by IIP's is subject to Health Insurance Portability and Accountability Act (HIPAA) and shall not be disclosed to any unauthorized person(s) without a written release signed by a parent(s) or guardian(s).

ATTACHMENTS:

Attachment A: Authorization for Release of Confidential Information

NOTE: The standards and procedures set forth herein are intended to establish operational guidelines for immediate intervention programs operating through the board of county commissioners and their employees/contractors and youth participating in the immediate intervention process. They are not intended to establish state created liberty interests for immediate intervention programs or the board of county commissioners, or their employees/contractors, or youth, or an independent duty owed by the Kansas Department of Corrections- Division of Juvenile Services to immediate intervention programs operating through the board of county commissioners or their employees/contractors, supervised juveniles or third parties. This standard and procedure is not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Regarding

Last Name:	First:	Middle:	Date of Birth:
Other names known by:			Social Security Number:

I(We) _____ authorize the following information to be disclosed as indicated below.

PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED:

Information to be released from: _____	Information to be released to: _____
<input type="checkbox"/> The Kansas Department of Corrections (KDOC): <input type="checkbox"/> The Department of Children and Families (DCF): <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility: _____ <input type="checkbox"/> Mental health practitioner, clinic, center or facility: _____ <input type="checkbox"/> Social Service agency or provider: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> The Kansas Department of Corrections (KDOC): <input type="checkbox"/> The Department of Children and Families (DCF): <input type="checkbox"/> School District: USD # _____ <input type="checkbox"/> Medical practitioner, clinic, center or facility: _____ <input type="checkbox"/> Mental health practitioner, clinic, center or facility: _____ <input type="checkbox"/> Social Service agency or provider: _____ <input type="checkbox"/> Other: _____

Information to be released: **(PLACE YOUR INITIALS TO THE LEFT OF EACH ITEM APPROVED)**

All information necessary to provide services
 Academic, achievement or aptitude evaluations and recommendations
 Social, behavioral, psychological, mental or medical histories and evaluations
 Diagnostic and treatment progress and prognoses
 Results of previous treatment
 Other (specify) _____

The purpose or reason for the release is:

(Optional: If no purpose stated, all lawful purposes are assumed)

Read before signing:

I understand that the information which I have authorized to be disclosed will be used for the purpose(s) stated. I acknowledge that it is my responsibility to be aware of any rights of confidentiality which I may have regarding the information which I am releasing and that by signing this consent I am waiving my rights, if any, to confidentiality for purposes which I have approved.

If I have authorized the release of information to a person or agency providing services under contract with DCF, I have also authorized release of the information to any person or agency providing that service under sub-contract.

This consent may be revoked in writing at any time prior to any action which has been taken in reliance upon it.
This consent expires upon (date): _____

Signature of person(s) giving consent: _____ Date: _____
_____ Date: _____

Relationship to person whose information is being released _____