MEDICAL PERMISSION FORM

Youth's Name: _____ **DJJ ID #:** _____

As parent or guardian of the youth named above, or as the above named youth, I give my permission for the Department of Juvenile Justice health care staff to administer any necessary non-psychiatric prescribed and/or over the counter medications and provide any medical, psychiatric, dental care or treatment and immunizations. I also authorize the Department of Juvenile Justice to provide for emergency hospital care, surgery, or special treatments to be performed by competent health care professionals.

Please check as applicable: (Please provide a copy of the insurance information or Medicaid card.)

- ❑ There is a health insurance policy that covers this child.
- ❑ There is Medicaid coverage for this child.

_____ _____

Signature of Youth (if 18 years of age or over) *Date*

_____ _____ _____

Signature of Parent or Guardian *Relationship* *Date*

CONSENT TO USE PROTECTED HEALTH INFORMATION

As the parent or guardian of the above named youth, or as the above named youth, I give my permission for the Department of Juvenile Justice (DJJ) staff to use protected health information in order to carry out treatment, payment or health care operations. Health information is any information that DJJ receives or creates that identifies (or could identify) a youth and deals with the youth's physical or mental health, any health care provided to the youth, and/or the payment for such health care.

DJJ has a Notice of Privacy Practices that describes in detail how protected health information might be used. The Notice also discusses your rights and DJJ's duties with respect to protected health information. You have the right to review the Notice of Privacy Practices before signing this consent. As provided in the Notice, DJJ's privacy practices may change. If there are any changes, you may obtain a revised copy of the Notice by contacting the DJJ Office of Legal Services, 3408 Covington Highway, Decatur, GA 30302.

You have the right to revoke this consent, in writing, except where DJJ has previously taken action in reliance on your prior consent. You also have the right to request that we restrict how the protected health information is used. DJJ is not required to agree to any restriction you request. However, if DJJ agrees to a restriction, it will be honored.

_____ _____

Signature of Youth (if 18 years of age or over) *Date*

_____ _____ _____

Signature of Parent or Guardian *Relationship* *Date*