George Junior Republic

IN INDIANA

Acknowledgement of OYS Goals and Expectations

I acknowledge that my OYS worker has reviewed with me the reason for the referral from DCS/probation and has discussed the following:

1. Expectation of the intensity of service
2. Contact information for GJR Older Youth Case Manager
3. Information regarding my potential eligibility for Chafee IL Services, Collaborative Care, and Chafee Voluntary Services.
4. Goals that may be listed on the referral

I understand DCS/Probation expects me to work with my Older Youth Case Manager to develop goals and learn skills that will assist me in achieving successful adulthood. I am expected to participate directly in designing my program activities, accept personal responsibility for achieving interdependence, and have opportunities to learn from both positive and negative experiences.

Goals in the below areas will be developed based on results of the Casey Life Skills Assessment and Learning Plan. This plan will be developed by me with assistance from my Older Youth Case Manager.

Education	Employment
Financial and Asset Management	Physical and Mental Health
Housing	Activities of Daily Living
Youth Engagement	

I understand that DCS/Probation also expects the following assessments/applications to be completed:

Casey Life Skills Assessment	Independent Living Learning Plan
FAFSA	ETV Applications
Emergency Contact List	Credit Check (if over 18yrs old)
Obtaining Vital Documents	21 Century Scholars Application/Scholar Track

Safety Concerns - are there any safety concerns in your home (i.e. weapons, bed-bugs, communicable diseases)?
____
____

Are there any cultural/religious considerations you want me to be aware of? ____________________________
____
____

______________________________ ________________
Printed name of client Date

______________________________ ________________
Signature of client Date

______________________________ ________________
GJR Older Youth Case Manager Date

YOUTH RIGHTS

Each youth receiving services from George Junior Republic in Indiana is entitled to certain rights as defined under the law. Employees of George Junior Republic in Indiana are responsible for ensuring that each youth's rights are respected. At no time is an employee permitted to take any action that violates the rights of a youth and each employee is responsible to read and understand the youth rights statement.

- A youth, the youth's family, and youth's placement may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age, gender identity, or sex.
- A youth has the right to be safe, nurtured and protected from youth abuse and neglect.
- A youth has the right to grow up in a supportive, stable home.
- A youth and their family have the right to be treated with fairness, dignity, and respect.
- A youth and their family have the right to be informed of the guidelines and expectations of the program.
- A youth and their family have the right to practice the religion or faith of choice, or not to practice any religion or faith.
- A youth has the right to appropriate medical and behavioral health.
- A youth has the right to humane rehabilitation and treatment.
- A youth has the right to an individualized, written learning plan to be developed promptly after admission.
- A youth has the right to be free from excessive medication.
- A youth may not be subjected to unusual or extreme methods of discipline, which may cause psychological or physical harm to the youth.
- A youth has the right to appropriate seasonal attire.
- A youth and the youth's family have the right to lodge a grievance with the program *for an alleged violation of specific client or civil rights* without fear of retaliation.
- A youth and their family have the right to confidentiality of records.
- A youth may not be deprived of specific client or civil rights.
- A youth's rights may not be used as a reward or sanction.

We have received and reviewed our rights with the George Junior Republic in Indiana, Inc. staff.

__________________________________ ________________________

PARENT OR GUARDIAN SIGNATURE DATE

__________________________________ ________________________

YOUTH SIGNATURE (IF APPLICABLE) DATE

George Junior Republic
IN INDIANA

CLIENT GRIEVANCE PROCEDURE

Each client, youth and parent or guardian has the right to lodge grievances without the fear of retaliation. The Client Grievance Procedure within George Junior Republic in Indiana is as follows:

1. If a problem, question, issue or situation arises regarding the client and/or family's treatment, it should first be discussed with the client's George Junior Republic in Indiana staff.

2. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the staff member, it should then be discussed with the George Junior Republic in Indiana direct supervisor. The supervisor is a managerial staff person and the direct supervisor of the staff.

3. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the supervisor, it should then be discussed with a director of Indiana.

4. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with a director, it should then be discussed with the Vice President of Indiana.

5. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the George Junior Republic in Indiana Vice President, it should then be discussed with the Human Resources Officer.

6. Also, please keep in mind that at any time, a client, youth, parent or guardian is encouraged to discuss any problems, questions, issues or concerns regarding the George Junior Republic in Indiana Program with the Probation Officer or Caseworker from the referring agency.

______________________________	______________________
CLIENT, PARENT OR GUARDIAN SIGNATURE	DATE
______________________________	______________________
YOUTH SIGNATURE (IF APPLICABLE)	DATE

GEORGE JUNIOR REPUBLIC IN INDIANA
CONSENT TO RECEIVE SERVICES

1. I, as the client (the term "I" and "client" shall mean the patient receiving the Services or the parent or legal guardian who is executing this Consent on behalf of the patient), understand that George Junior Republic in Indiana ("GJR") provides an array of services, such as home-based and office-based individual, group or family therapy, case-management, diagnostic and evaluation testing, assessments, random drug screens, independent living as well as other interventions as outlined by referral sources. In-person, virtual, or telephonic services will be utilized when appropriate. I understand that the client and/or client's family will be provided services on an ongoing basis as defined in the client's treatment plan ("Services") and I consent to the provision of Services. I understand such Services will be provided by an appropriate level of direct care worker as defined by Indiana state service standards regarding scope of education, training, and experience.

2. I understand that communication through social media including, but not limited to, Facebook, encrypted email, Skype, oovoo, MySpace, Zoom, Teams, Twitter, Duo, Google+ and text messaging may be used and that every attempt will be made to avoid, limit and protect disclosing personal health information [PHI].

3. I understand that the following information has been explained to me before the commencement of Services:
   a. Client's status giving rise to the proposed Services
   b. Proposed Services to be rendered to the client.
   c. Expected outcome of such Services.
   d. Material risks of such Services.
   e. Reasonable alternatives to Services.

4. I understand that I have a right to withdraw this consent for Services at any time by notifying, in writing or verbally, GJR.

5. I understand GJR may terminate services by notifying the client verbally or in writing, of the reasons for termination, and that GJR will refer the client for alternate treatment services if requested or required.

6. I understand that if emergency medical care or treatment is needed for the client I consent to GJR obtaining such emergency medical care or treatment. I understand that I will be

financially responsible for any such emergency medical care or treatment obtained by GJR for the client.

7. I have had sufficient opportunity to discuss the client's condition with a representative of GJR. I understand the potential benefits of the Services and all of my questions have been answered to my satisfaction.

8. I understand the contents of this consent form. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction.

9. I acknowledge that I have adequate knowledge upon which to base an informed consent to the Services.

____ ________________ ________________
CLIENT SIGNATURE DATE OF BIRTH DATE SIGNED

____
Printed Client Name

____ ________________
PARENT / LEGAL GUARDIAN SIGNATURE DATE SIGNED
(Parent or Legal guardian must sign if Patient is under the age of 18 years)

____
Printed Name of Parent/Legal Guardian

____ ________________
WITNESS SIGNATURE DATE SIGNED

____
Printed Name of Witness

RESPONSIBLE PARTY CONFIRMATION FORM

George Junior Republic of Indiana (“GJR”) provides home-based, group home, office-based, and other consultation services to clients of GJR. Due to the nature of GJR’s services, there may be times when a person other than client’s parent has been assigned responsibility for making health care decisions for a client. Such person may be a guardian, health care representative, or special advocate, appointed by the court, or other person otherwise authorized to make decisions on behalf of the client (the “Responsible Party”). To ensure GJR communicates with and obtains consent from, the proper person regarding the client, this form notifies GJR when a person other than the parent has been established as a Responsible Party.

In addition to completing this form, when there is a Responsible Party, legal documentation confirming the authority of the Responsible Party must be submitted to GJR. An example of such legal documentation is a copy of the court order establishing the guardianship or representation. GJR retains the right to withhold treatment or otherwise withhold communication about the client to the person, unless GJR receives such legal documentation supporting the Responsible Party’s authority.

Section 1. Client Information

Name of Client: ____

Date of Birth: ____

Section 2. Confirmation of Responsible Party

Please check the applicable box:

☐ I am the parent of the client and there is <u>not</u> currently a Responsible Party appointed for the client.

If this box is checked, complete Section 3 and Section 5.

☐ I am the parent, but do not have the authority to make health care decisions on behalf of the client due to the appointment of a Responsible Party.

If this box is checked, complete Section 3, Section 4 with information about the Responsible Party, and Section 5.

☐ I am the Responsible Party and have the authority to make health care decisions on behalf of the client due to my appointment as (check the applicable circle):

- o Judicially-appointed guardian
- o Health care representative
- o Court appointed special advocate
- o Other person authorized to make health care decisions on behalf of the client. Please describe ____

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IN INDIANA

If this box is checked, complete Section 4 with your information and Section 5.

Section 3. Parent Information

Mother
Name of Mother: ______________________________
Date of Birth: ______________________________
Home Address: ______________________________
Phone Number (Home): ______________________________
Phone Number (Cell): ______________________________
Name of Employer: ______________________________
Phone Number (Work): ______________________________

Father
Name of Father: ______________________________
Date of Birth: ______________________________
Home Address: ______________________________
Phone Number (Home): ______________________________
Phone Number (Cell): ______________________________
Name of Employer: ______________________________
Phone Number (Work): ______________________________

Section 4. Responsible Party Information

Name of Responsible Party: ______________________________
Date of Birth: ______________________________
Home Address: ______________________________
Phone Number (Home): ______________________________
Phone Number (Cell): ______________________________
Name of Employer: ______________________________
Phone Number (Work): ______________________________
Relationship to Client: ______________________________
Effective Date of Status
as Responsible Party: ______________________________
Termination Date/Event of
Status as Responsible Party: ______________________________

Please also provide a copy of the legal documentation confirming the authority of the Responsible Party.

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Section 5. Attestation and Signature

I have read and understand the above information. By signing this form, I attest that I have completed this form to the best of my knowledge regarding the person who has the legal authority to make decisions on behalf of the client.

Name of Parent/Responsible Party (Print): ____
Signature of Parent/Responsible Party: ____
Date: ____

GJR Staff Signature: ____
Date: ____

GJR Staff Use Only
Legal Documents Supporting Responsible Party Provided? Y / N
Copy of Legal Document Placed in Client Record? Y / N

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TRANSPORTATION CONSENT AND RELEASE

I, the undersigned, do hereby consent to the transportation of ______________________________ (the "Client" [s]), by George Junior Republic in Indiana, Inc. ("GJR"), its agents, therapists, employees, and independent contractors (each individually and collectively, "GJR Representatives").

By signing this Form, I hereby release and agree to hold harmless GJR and GJR Representatives, from any and all claim(s) stemming from or in any way relating to the transportation of the Individual, whether the Individual is being transported to or from GJR by a GJR Representative at the time the client(s) is allegedly injured as a result of said GJR Representative's alleged negligence or otherwise allegedly tortuous conduct. I understand and acknowledge this Form will be in effect regardless of the nature or seriousness of any and all injuries which may be sustained by the client(s) while or as a result of the client being transported by a GJR Representative.

Prior to signing this Form, I have had sufficient opportunity to independently consider and/or to consult with an attorney to ask questions regarding the meaning and significance of this Form. I understand and agree to all of the terms of this Form and acknowledge that in so doing I have not relied upon any statement, explanation or promise by any GJR Representative, with regard to the meaning, scope or effect of this Form.

____
(Printed Name of Individual or Parent/Guardian on behalf of Individual)

____
(Signature of Individual or Parent/Guardian on behalf of Individual) (Date)

____
(Printed Name of Witness)

____
(Signature of Witness) (Date)

George Junior Republic
IN INDIANA

RELEASE FORM - Transportation/Group Activities

I, ________________________________,____________________________ do hereby consent to
(Name of Client) (Date of Birth)
involvement in group tasks and transportation with other youth in the George Junior Republic programs.

_________________________________ _________________________________
(Signature of Client, Parent, or Guardian) (Date)

_________________________________ _________________________________
(Signature of Witness) (Date)

The Department of Child Services or Juvenile Probation is the guardian of

__________________________ and consents to this youth participating in groups and/or transportation with other youth involved in the George Junior Republic program.

_________________________________ _________________________________
(Signature of Parent/Guardian/Referral Agency) (Date)

_________________________________ _________________________________
(Signature of Witness) (Date)

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ________________________________

Client Address: ________________________________

Client Date of Birth: ________________________________

I, ____ do hereby consent
(Name)

and authorize unrestricted communications between____________________ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

1. Assessment/diagnosis in treatment/counseling
2. Attendance/participation in treatment/counseling
3. Progress and prognosis in treatment/counseling
4. Verbal Communication
5. Progress notes
6. Discharge summary/completion letter
7. Information relevant to facilitation of compliance with GJR Program
8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _______________________

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless

otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  > "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

  (Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

____

Signature of Client (if 13 year or older) Date

____

Signature of Personal Representative* Date

GeorgeJuniorRepublic
IN INDIANA

____
*Nature of Relationship between Personal Representative and Client, where applicable

____
Signature of Witness   Date

____
Printed Name of Witness

GeorgeJuniorRepublic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ________________________________

Client Address: ________________________________

Client Date of Birth: ________________________________

I, ____ do hereby consent
(Name)

and authorize unrestricted communications between ___________________ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

8. Assessment/diagnosis in treatment/counseling
9. Attendance/participation in treatment/counseling
10. Progress and prognosis in treatment/counseling
11. Verbal Communication
12. Progress notes
13. Discharge summary/completion letter
14. Information relevant to facilitation of compliance with GJR Program

8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: ______________________

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless

otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  > "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

(Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

____
Signature of Client (if 13 year or older) Date

____
Signature of Personal Representative* Date

____
*Nature of Relationship between Personal Representative and Client, where applicable

____
Signature of Witness Date

____
Printed Name of Witness

GeorgeJuniorRepublic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ________________________________

Client Address: ________________________________

Client Date of Birth: ________________________________

I, ____ do hereby consent
(Name)

and authorize unrestricted communications between ___________________ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

15. Assessment/diagnosis in treatment/counseling
16. Attendance/participation in treatment/counseling
17. Progress and prognosis in treatment/counseling
18. Verbal Communication
19. Progress notes
20. Discharge summary/completion letter
21. Information relevant to facilitation of compliance with GJR Program

8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: ______________________

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless

otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  > "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

  (Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

____

Signature of Client (if 13 year or older) Date

____

Signature of Personal Representative* Date

____
*Nature of Relationship between Personal Representative and Client, where applicable

____
Signature of Witness Date

____
Printed Name of Witness

George Junior Republic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ________________________________

Client Address: ________________________________

Client Date of Birth: ________________________________

I, ____ do hereby consent
(Name)

and authorize unrestricted communications between ________________(Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

22. Assessment/diagnosis in treatment/counseling
23. Attendance/participation in treatment/counseling
24. Progress and prognosis in treatment/counseling
25. Verbal Communication
26. Progress notes
27. Discharge summary/completion letter
28. Information relevant to facilitation of compliance with GJR Program

8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _______________________

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless

otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  > "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

  (Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

____

Signature of Client (if 13 year or older) Date

____

Signature of Personal Representative* Date

____

*Nature of Relationship between Personal Representative and Client, where applicable

____

Signature of Witness Date

____

Printed Name of Witness

George Junior Republic
IN INDIANA

MEDIA AND PHOTOGRAPHY CONSENT

Last Name of Person Served:	First Name of Person Served:

As a person served and/or as a parent/guardian of a person receiving services from George Junior Republic ("GJR") and its affiliates, (George Junior Republic in Pennsylvania (GJR in PA), George Junior Republic in Indiana (GJR in IN), and/or George Junior Republic Preventative Aftercare (GJR PAC)), you have the right to consent to use of your and/or your child's personal information (name, image, likeness, voice, achievements and/or activities).

If consent is granted, the personal information can be used in each organization's press releases, newsletters, photography, videos (including voices), recordings, fundraising materials, "broadcasts" or other information dissemination provided on television, radio, computers, phones, social media, blogs, podcasts, mobile devices or apps, the GJR website, other websites or online services, and other existing or future ways to release information. The personal information may be used locally, nationally, or internationally and in all possible existing or future media (now known or unknown).

Purposes: The above referenced media and photography opportunities support each organization's advertising, fundraising, education, mission, programs, persons served, community, activities or outreach efforts.

By checking "Yes" and providing my signature below:

- I acknowledge that I have all the necessary permissions and lawful authority to provide this consent so that it is legally binding;
- I give consent to GJR in PA, GJR in IN, and/or GJR PAC agents and service providers to publish and/or release the personal information about myself or my child identified above, all without payment to me, my child, if applicable, or any other party;
- I understand that I may withdraw this consent by writing GJR in PA, GJR in IN, and/or GJR PAC at 233 George Junior Road, Grove City, PA 16127, and agree, for myself or my child, that any withdrawal of consent will not affect any item already published based on the initial consent.

☐ Yes, I am providing media and photography consent.
☐ No, I am not providing media and photography consent at this time.

Persons Served or Parent/Guardian Printed Name	***Persons Served or Parent/Guardian Signature***	***Date***
***Please note that some placing agencies prohibit the use of personal information regardless of parental consent.**		

This section is for VERBAL CONSENTS ONLY: Verbal consent requires **TWO** witness signatures as.

Witness 1: GJR Representative Printed Name	***Witness 1: GJR Representative Signature***	***Date***
Witness 2: Placing Agency or GJR Representative Printed Name	***Witness 2: Placing Agency or GJR Representative Signature***	***Date***

GeorgeJuniorRepublic
IN INDIANA

I ____ acknowledge that I have received a copy of GEORGE JUNIOR REPUBLIC IN INDIANA'S NOTICE OF PRIVACY PRACTICES
and had the opportunity to ask questions.

____
Name of Client

____
Signature of the client or the client's personal representative if the client cannot make health care decisions for him/herself.

____
Witness Signature

____
Date

____
Date