# Child & Family Center

*A Program of Heartland Family Service*

HEARTLAND FAMILY SERVICE
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## Client Forms Index

Child & Family Center
*A Program of Heartland Family Service*

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# Heartland Family Service Client Intake Form *(Confidential)*

**Today's Date:** _____/ _____/ _____

**By filling out the information below, I certify that I have authorization to consent for therapeutic services on behalf of the child/adolescent listed below. Please initial** _____

**Parent/ Legal Guardian** *(sign here)*: _____

**Parent/ Legal Guardian** *(sign here)*: _____

**Please circle the type of evaluation needed today:** MENTAL HEALTH SUBSTANCE USE BOTH

**Client Name:** _____

**Gender:** *(Please circle one)*: Male Female Transgender Unknown

**Client Date of Birth:** _____/ _____/ _____ **Age today:** _____

**Client Social Security Number:** _____- ____ - _____

**How would you identify their ethnicity?** *(Please circle one)*:

Cuban Mexican Puerto Rican Hispanic or Latino Not Spanish/ Hispanic/ Latino

Unknown Other_____

**How would you identify their race?** *(Please circle one)*:

Alaskan Native Alaskan Indian Asian Black/African American Caucasian Hawaiian or Pacific

Islander Unknown Other _____

**Preferred language?** _____ **Is the Client a U.S. Citizen:** YES NO

**Client's Address:**

_____

**Client's phone number:** (_____) _____- _____ *(circle one)* Mobile Home Work

**Name:** _____ **Relationship:** _____

**Client's second phone number:** (_____) _____- _____ *(circle one)* Mobile Home Work

**Name:** _____ **Relationship:** _____

**Emergency contact number:** (_____) _____- _____ **Name:** _____

***May we leave voice mail messages and state we are with Heartland Family Service?*** YES NO

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# Heartland Family Service Client Intake Form *(Confidential)*

**Is it just you and the client in the home, or are you married and/or do you have other children?**

_____

**Who referred you to the Child & Family Center?** _____

**Has your child(ren) had recent thoughts of suicide?** YES NO

**Has your child(ren) been recently hospitalized?** If so, please explain:

_____

**Does your child(ren) have any pending court dates, or has had court recently?** YES NO

**Please explain the charge(s)** *(if applicable):*

_____

**Name of Probation Officer** *(if applicable):* _____

**Please explain presenting concerns to help our therapists assist your child(ren) further:**

_____

_____

**Previous or current therapist name and agency** *(if applicable)*:

_____

**May we contact this agency/ therapist for collateral information?** YES NO

**What is your approximate annual household income?** *(Please circle one)*

0-$10,000 $10,000-$14,999 $15,000-$24,999 $25,000-$34,999 $35,000-$49,999

$50,000-74,999 $75,000-$99,999 $100,000 & Up Other _____

**Insurance Company Name(s)**: _____

**Policy Holder's Name(s):** _____

**Policy Holder's SS# and/or ID Number(s):** _____

**Policy Holder's Group# (s):** _____

Completed by: _____ Relationship: _____

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# Behavioral Health Outpatient Program Agreement

**Adult/Adolescent**

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***To ensure quality care in a safe, healing environment, it is important for you to know the kinds of services being provided as well as the guidelines and expectations under which these services will be offered.***

1. Your safety and the safety of others are important to us. Please talk to your therapist if your safety is at risk including thoughts to harm yourself or others, thoughts of suicide, or thoughts of relapse. The on call therapist can be reached 24 hours a day to address any immediate safety concerns you have at 402-553-3000.

2. We commit to maintaining your confidentiality and ask that you do the same for other clients. All matters discussed in group sessions and the identities of all group members are absolutely confidential and will not be shared with nonmembers, including verbal communication or postings on any social media *(such as Facebook or Twitter)* sites. Written permission from the client must be in place according to Federal Confidentiality rules 42 CFR Part 2 for substance abuse and HIPAA in order for us to release any client information. The only exceptions are when disclosure is required or permitted by law which typically involves substantial risk of physical harm to oneself or to others or suspected abuse of children or dependent adults.

3. Heartland Family Service (HFS) is a drug free, tobacco free, and weapon free facility.

4. As a client of HFS you have the right to express your opinion and grievances without retribution regarding all aspects of HFS. Procedures to file a grievance on any HFS employee or program are available at the front desk or from your therapist upon request.

I certify that I have read, understand and am committed to this **Behavioral Health Outpatient Program Agreement**. This agreement and consent covers the length of time I am involved in treatment activities at Heartland Family Service. *(Please sign below)*

| | |
|---|---|
| _____ | _____ |
| Client's Name | Client's Signature |
| _____ | _____ |
| Parent/Legal Guardian | Today's Date |
| _____ | _____ |
| Staff's Signature | Today's Date |

# Health History

Heartland Family Service has a holistic and integrated philosophy of care. Mental health conditions, addiction and trauma can be very stressful to the body as well as the mind. We ask for your health history to fully assess your needs and make the best and most comprehensive recommendations for your treatment and services. All information is confidential

| **Date:** | **Name:** | **Date of Birth:** |
|---|---|---|

**Please indicate if you have now, or have had in the past, any of these conditions.**

| | **Current** | **Past** | | **Current** | **Past** |
|---|---|---|---|---|---|
| Head Injury | | | High Blood Pressure | | |
| Blackouts | | | Diabetes | | |
| Migraines | | | Asthma | | |
| Headaches | | | Skin Conditions | | |
| Seizures | | | Kidney Problems | | |
| Lupus | | | Liver Problems | | |
| Fibromyalgia | | | Heart Problems | | |
| Stroke or TIA | | | Respiratory Problems | | |
| Dizziness | | | Vision Problems | | |
| Sleep Difficulties | | | Hearing Problems | | |
| Paralysis | | | Back or Neck Pain | | |
| Stomach or GI problems | | | Thyroid Problems | | |
| Gynecological Problems | | | Cancer | | |
| Sexually Transmitted Disease | | | Females: Pregnancy | | |

**Other medical conditions not included above:**

| | |
|---|---|
| **Current Nicotine / Tobacco Use:** ☐ Yes ☐ No<br>**(if yes, how much per day):** _____ | **If yes, would you like to receive information on or help with cessation?** ☐ Yes ☐ No |

**Caffeine Use (how much, how often):**

**Allergies:**

*When life improves for one of us, life improves for all of us. We all matter.*

**Current Medications:** Please include prescription and non-prescription medications and check if you are regularly taking these medications

| Name of Medication | Dosage/Frequency | Prescribed by | Reason Taken | Check if taking |
|---|---|---|---|---|
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

| | |
|---|---|
| **Primary Care Physician**<br>**Name:**<br>**Address:**<br>**Phone Number:** | **If you do not have a primary care physician would you like a referral?** ☐ Yes ☐ No |
| **Date of Last Physical Exam:** | **Date of Last Dental Exam:** |

**Tuberculosis Screening:** Please indicate if you currently have any of the following symptoms

| | | | |
|---|---|---|---|
| ☐ Weakness or Fatigue | ☐ Weight Loss | ☐ Fever | ☐ Night Sweats |
| ☐ Persistent Cough | ☐ No Appetite | ☐ Coughing up Blood | ☐ Chills |

| | |
|---|---|
| **Have you ever had a TB Test?** ☐ Yes ☐ No | **Results:** ☐ Positive ☐ Negative |

**Did you have a chest x-ray or other tests to confirm or rule out TB?** ☐ Yes ☐ No

**Have you lived in the same environment with someone else who has/had TB or who was at high risk for TB?** ☐ Yes ☐ No

**If your history has placed you at risk for having TB, it will be necessary for you to have a TB test and provide documentation of the results prior to receiving any further services from HFS.**

**HIV/AIDS**

| | |
|---|---|
| **Have you ever been tested for HIV?** ☐ Yes ☐ No | **Results:** ☐ Positive ☐ Negative |

**Have you lived in the same environment with someone else who has HIV or AIDS?** ☐ Yes ☐ No

**Hepatitis**

| | |
|---|---|
| Have you ever had a test for hepatitis? ☐ Yes ☐ No | If positive, have you received treatment? ☐ Yes ☐ No |

**Have you lived in the same environment with someone else who has/had hepatitis or who was at high risk for hepatitis?** ☐ Yes ☐ No

**For Staff Use**

| | |
|---|---|
| **Referred for TB Test?** ☐ Yes ☐ No | **Was a Health Referral Made?** ☐ Yes ☐ No |
| **Any additional information:** | |
| **Client Signature:** | **Therapist Signature:** |

Child ID#: _____ Child age _____

Caregiver: _____ Date: _____

# Pediatric Symptom Checklist-17 (PSC-17)

**INSTRUCTIONS*:*** Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

| | **Please mark under the heading that best fits your child** | | | ***For Office Use*** | | |
|---|---|---|---|---|---|---|
| **Does your child:** | **Never** | **Sometimes** | **Often** | **I** | **A** | **E** |
| 1. Feel sad. | ☐ | ☐ | ☐ | | | |
| 2. Feel hopeless. | ☐ | ☐ | ☐ | | | |
| 3. Feel down on him/herself. | ☐ | ☐ | ☐ | | | |
| 4. Worry a lot. | ☐ | ☐ | ☐ | | | |
| 5. Seem to be having less fun. | ☐ | ☐ | ☐ | | | |
| 6. Fidget, is unable to sit still. | ☐ | ☐ | ☐ | | | |
| 7. Daydream too much. | ☐ | ☐ | ☐ | | | |
| 8. Distract easily. | ☐ | ☐ | ☐ | | | |
| 9. Have trouble concentrating. | ☐ | ☐ | ☐ | | | |
| 10. Act as if driven by a motor. | ☐ | ☐ | ☐ | | | |
| 11. Fight with other children. | ☐ | ☐ | ☐ | | | |
| 12. Not listen to rules. | ☐ | ☐ | ☐ | | | |
| 13. Not understand other people's feelings. | ☐ | ☐ | ☐ | | | |
| 14. Tease others. | ☐ | ☐ | ☐ | | | |
| 15. Blame others for his/her troubles. | ☐ | ☐ | ☐ | | | |
| 16. Refuse to share. | ☐ | ☐ | ☐ | | | |
| 17. Take things that do not belong to him her. | ☐ | ☐ | ☐ | | | |
| ***TOTAL*** | | | | | | |

**To Score:**

Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

**Positive Scores:**

| | |
|---|---|
| PSC17-I | $\geq 5$ |
| PSC17-A | $\geq 7$ |
| PSC17-E | $\geq 7$ |
| Total Score | $\geq 15$ |



PSC 17 Gardner W, Murphy M, Childs G et al. (1999)

# GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

| The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.<br><br>After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0). | Past month | 2 to 12 months ago | 1+ years ago | Never |
|---|---|---|---|---|
| | 3 | 2 | 1 | 0 |

IDScr

1. <u>When was the last time</u> that you had <u>significant</u> problems…
   a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? ..... 3 2 1 0
   b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? ..... 3 2 1 0
   c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? ..... 3 2 1 0
   d. with becoming very distressed and upset when something reminded you of the past? ..... 3 2 1 0
   e. with thinking about ending your life or committing suicide? ..... 3 2 1 0

EDScr

2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?
   a. Lied or conned to get things you wanted or to avoid having to do something? ..... 3 2 1 0
   b. Had a hard time paying attention at school, work, or home? ..... 3 2 1 0
   c. Had a hard time listening to instructions at school, work, or home? ..... 3 2 1 0
   d. Were a bully or threatened other people? ..... 3 2 1 0
   e. Started physical fights with other people? ..... 3 2 1 0

SDScr

3. <u>When was the last time</u> that…
   a. you used alcohol or other drugs weekly or more often? ..... 3 2 1 0
   b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? ..... 3 2 1 0
   c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? ..... 3 2 1 0
   d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? ..... 3 2 1 0
   e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? ..... 3 2 1 0

| (Continued)<br><br>After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0). | Past month | 2 to 12 months ago | 1+ years ago | Never |
|---|---|---|---|---|
| | 3 | 2 | 1 | 0 |

CVScr

4. <u>When was the last time that you</u>…

| | | | | |
|---|---|---|---|---|
| a. had a disagreement in which you pushed, grabbed, or shoved someone? | 3 | 2 | 1 | 0 |
| b. took something from a store without paying for it? | 3 | 2 | 1 | 0 |
| c. sold, distributed, or helped to make illegal drugs? | 3 | 2 | 1 | 0 |
| d. drove a vehicle while under the influence of alcohol or illegal drugs? | 3 | 2 | 1 | 0 |
| e. purposely damaged or destroyed property that did not belong to you? | 3 | 2 | 1 | 0 |

5. Do you have other <u>significant</u> psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below)..... <u>Yes</u> 1 <u>No</u> 0

v1. _____

v2. _____

v3. _____

6. What is your gender? (If other, please describe below) ……1-Male 2-Female 99-Other

v1. _____

7. How old are you today? |__|__| years

**For Staff Use Only**

8. Site ID: _____ Site Name v. _____
9. Staff ID: _____ Staff Name v. _____
10. Client ID: _____ Comment v. _____
11. Mode: 1) Administered by staff 2) Administered by other 3) Self-administered
12. Number of 2s and 3s: IDSscr: ____ EDScr: ____ SDScr: ____ CVScr: ____ TDScr: ____
13. Referral: MH____ SA ____ ANG ____ Other ____ 14. Referral Code: _____
15. Referral comments:

v1. _____

v2. _____

v3.

# PHQ-9: Modified for Teens

**Name:** _____ **Clinician:** _____ **Date:** _____

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

| | *(0)* **Not At All** | *(1)* **Several Days** | *(2)* **More Than Half the Days** | *(3)* **Nearly Every Day** |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | | | | |
| 2. Little interest or pleasure in doing things? | | | | |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | | | | |
| 4. Poor appetite, weight loss, or overeating? | | | | |
| 5. Feeling tired, or having little energy? | | | | |
| 6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down? | | | | |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | | | | |
| 8. Moving or speaking so slowly that other people could have noticed?<br><br>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? | | | | |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | | | | |

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [ ] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

**Office use only: Severity score:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

# Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult….) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year…) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

| **Total Score** | **Depression Severity** |
|---|---|
| 0-4 | No or Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |

Child & Family Center

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# Informed Consent for Communication by Electronic Means

**Client Name:** _____ **Date of birth:** _____

**Therapist:** _____ **Date:** _____

☐ **routine scheduling or changing of appointments** ☐ **communicating between sessions as part of the service plan**

☐ **email:** _____ ☐ **text message (number):** _____

**Cellular Plan Carrier:** _____

**Comments:**

**I understand that electronic communication must not be used for urgent or emergency situations and that I must use the telephone including emergency/on call access in an emergency where immediate response is needed.**

**Risks of Electronic Communication:**

- **Electronic communication may be sent but not received or delivered to the wrong party**
- **Confidentiality may be breached by electronic communication being intercepted on either the sending or receiving side, or in transits**

## Benefits of Electronic Communication:

- **Access to send messages at any time**
- **Opportunity to compose email messages and responses thoughtfully**
- **Record of communications for ongoing reference**

## Alternatives of Electronic Communication:

- The alternative to email communication includes personal discussion in sessions, and telephone calls.
- I understand that I am responsible for safeguarding my sent and received electronic communications from access by others in my home or work environment; or from shared or public devices if applicable. I understand that a separate password protected email account is preferable.
- Through my email carrier, I may request "return receipt" to acknowledge that the email has been received.
- I understand that email from my work account is not confidential and should not be used for any sensitive information.
- I understand that electronic communication is not to be used for any emergency or urgent communications. I agree to follow established emergency contact procedures.
- I understand that my electronic communication will be kept as part of my service record.
- My HFS staff and I may establish guidelines as necessary regarding the volume and frequency of email communication which support effective services.
- I may revoke my consent for electronic communication at any time by informing staff.
- Heartland Family Service may opt to discontinue electronic communication if it is inappropriate or unsafe to continue it.
- I understand that Heartland Family Service has established, and adheres to, confidentiality practices for electronic communication received by employees.

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or canceled by me ***in writing*** or until. *(Not more than 12 months)* End Date: _____

| | | | |
|---|---|---|---|
| Client Print Name | Date | Staff Print Name | Date |
| Client Signature | Date | Staff Signature | Date |

# HEARTLAND FAMILY SERVICE

## CHILD AND FAMILY CENTER

Professional Counseling Primary Care Release

## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

*Heartland Family Service has a holistic and integrated philosophy of care. Mental health conditions, addictions, and trauma can be very stressful to the body as well as the mind. Collaboration between your physician and therapist can promote physical as well as emotional recovery. With your consent, we will coordinate care with your primary care doctor or other health professional.*

*If you do not consent for us to contact your physician, please check here ☐ and initial here___ Date _____*

*TO:* _____ *From:* **Heartland Family Service**

_____ _____

_____ _____

_____ **ATTN:** _____

Phone:(___)_____ FAX:_____ Phone: (__)___-_____ FAX:_____

**RE:**_____ **Birth Date:**_____ **SSN#**_____

This is to authorize _____ to ❑ release to and/or ❑ receive from

**Heartland Family Service** confidential information, including, but not limited to, professional opinions, reports of tests and examinations, treatment summaries, diagnosis and prognosis.

*Specific information to disclose is as follows:*

| | |
|---|---|
| ☐ Initial evaluation | ☐ Attendance and compliance |
| ☐ Substance use related diagnosis and treatment | ☐ Medical / health |
| ☐ Treatment plan | ☐ HIV / AIDS Status |
| ☐ Progress notes | ☐ Educational records |
| ☐ Progress reports | ☐ Legal history |
| ☐ Psychiatric evaluation | ☐ Treatment Summary (discharge summary) |
| ☐ Psychological evaluation | **OTHER:** _____ |

***The reason for this disclosure is to Coordinate Medical Care***.

I am authorizing the release of confidential information that is to be used in conjunction with the professional services I am receiving. I understand that no services will be denied to me solely because I refuse to consent to the release of information. I understand that I am not required in any way to sign this release. I understand that I am able to receive a copy of the release upon request; a copy of this authorization is as good as the original.

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or canceled by me ***in writing*** or until

**DATE** _____ *(not more than 90 days if one time disclosure or not more than 12months if ongoing disclosure)* .

**I understand that the records released may include drug and alcohol related information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent.**

_____ _____

Print Legal Name Parent / Guardian Signature

_____ _____

Sign Legal Name Date Signed

_____ _____

Witnessed by Date Signed

*Relationship to patient/client (✓Check one box):* ❑ - self ❑ - parent ❑ - legal guardian

# HEARTLAND FAMILY SERVICE
# CHILD AND FAMILY CENTER
## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

*TO:* _____ *From:* **Heartland Family Service**

_____ _____

_____ _____

_____ **ATTN:** _____

Phone:___)_____ FAX:_____ Phone:_____FAX _____

**RE:**_____ **Birth Date:**_____**SSN#**_____

This is to authorize _____to ❑ release to and/or ❑ receive from

**Heartland Family Service** confidential information, including, but not limited to, professional opinions, reports of tests and examinations, treatment summaries, diagnosis and prognosis.

*Specific information to disclose is as follows:*

| | |
|---|---|
| ☐ Initial evaluation | ☐ Attendance and compliance |
| ☐ Substance use related diagnosis and treatment | ☐ Medical / health |
| ☐ Treatment plan | ☐ HIV / AIDS Status |
| ☐ Progress notes | ☐ Educational records |
| ☐ Progress reports | ☐ Legal history |
| ☐ Psychiatric evaluation | ☐ Treatment Summary (discharge summary) |
| ☐ Psychological evaluation | ☐ Other: _____ |
| | _____ |

The reason for this disclosure is:_____

I am authorizing the release of confidential information that is to be used in conjunction with the professional services I am receiving. I understand that no services will be denied to me solely because I refuse to consent to the release of information. I understand that I am not required in any way to sign this release. I understand that I am able to receive a copy of the release upon request; a copy of this authorization is as good as the original.

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or canceled by me ***in writing*** or until

**DATE** _____ *(not more than 90 days if one time disclosure or not more than 12months if ongoing disclosure)*

**I understand that the records released may include drug and alcohol related information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent.**

_____ _____
Print Legal Name Parent / Guardian Signature

_____ _____
Sign Legal Name Date Signed

_____ _____
Witnessed by Date Signed

*Relationship to patient/client (✓Check one box):* ❑ - self ❑ - parent ❑ - legal guardian