Release Authorization Form for a Trauma Informed Referral & Assessment

I, ______________________________________, hereby authorize ____, its administrator or designee, ________________________________, to release information regarding the below-named child to the following agencies/persons for the purpose(s) specified – please initial each one:

____ to LACASA to process the referral

____ to the Oversight Committee for the Trauma Informed System of Care to review the referral and determine eligibility (The Trauma Informed System of Care Oversight Committee includes the following agencies and their representatives/designees: LACASA as the lead organization, Community Mental Health, Department of Human Services, Livingston County Courts, LESA, parent liaison)

____ Only if approved for the assessment, to the Trauma Informed Assessment Team to coordinate and complete a Trauma Informed Assessment

Name of Child ____ Date of Birth _________________

Specific Information to be Disclosed/Exchanged – Initial each one as applicable:

____ Copy of evaluations completed in the year

____ Mental Health Assessments/Intakes

____ Family Background

____ Description of treatments/services utilized

____ Current diagnosis

____ Psycho-Social history

____ Substance Abuse/Alcohol Use records*

____ Educational History

____ Copies of treatment plans

____ Medical history

____ Other: ____

This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished. However, this consent shall be valid no longer than is reasonably necessary to accomplish the purpose for which it is given. This consent will automatically expire 90 days from the date it is signed unless revocation is made prior to this date.

*I also understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without proper written consent unless otherwise provided for in the regulations.

A copy of this authorization shall be no less valid than the original.

My signature verifies my authorization for information release and exchange and that I have read this form and/or have had it read to me and explained in a language I can understand.

____ ________________________________

Client/Parent/Guardian Signature Date Signed

____ ________________________________

Witness Signature Date Signed

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24-Hour Toll-Free **HELP LINE** (866) 522-2725