Consent for Sharing Information Between Member Agencies

Student's Full Name:

Student's Date of Birth: Age: Grade:

School District: School Name:

Referring Agency: Referring Contacts:

I_____(print legal guardian name) authorize the _____ (county) System of Care Team which may consist of the following agencies to share information to better support my child and family.

Check the agency/agencies below that currently or in the past supported the student/family.

- ☐ Hospital
- ☐ Children's Division
- ☐ Community Council Coordinated Entry
- ☐ Compass Health Network
- ☐ F.A.C.T.
- ☐ Police Department (local, if involved)
- ☐ Preferred Family Healthcare
- ☐ Probation and Parole (if involved)
- ☐ Regional Office
- ☐ School District
- ☐ SOC Representative
- ☐ Juvenile Court
- ☐
- ☐
- ☐

The following type of information may be discussed in an effort to coordinate services and provide a comprehensive support system: Discharge summary, Legal information, Program(s) participation, Evaluation results, Medical Information, Psychological Information. The purpose of sharing this information is to provide collaborative and comprehensive support and programming for your child and family.

I understand that my records are protected under the Family Educational Rights and Privacy Act (FERPA), the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.

INITIAL for Drug and Alcohol information:_____

_____ _____

Signature of Parent/Guardian/Legal Rep Date

_____ _____

Signature of Witness Date

Specify witness relationship to family: _____

cc: Parent
Educational Support Counselor
Agencies

Rev Sept. 2023