CHILD's RELEASE

114 S Alabama Ave., Deland, FL 32724, Tel: 386-734-2236, Fax: 386-943-8823

AUTHORIZATION FOR RELEASE OF INFORMATION
For the Purpose of Assessing Family Progress and Needs for Services

I….. Name: _____as the Parent or Legal Guardian of Child's Name_____

Social Security Number: _____

Authorize the release of information as stated below:

NOTE: A SEPARATE RELEASE MUST BE SIGNED FOR EACH CHILD IN THE HOUSEHOLD

I understand that this information will be used solely to assist in providing appropriate services and will be held in strictest confidence. I also understand that in specific circumstances, where required by law and as defined by the Agency's Notice of Privacy Practices, that my protected information may be subject to re-disclosure. I understand that I may revoke this Authorization at any time by giving written notice to The House Next Door listed above, except to the extent that action has been taken in reliance thereon. I understand that my refusal to authorize release of records or revoking authorization will not prevent me from receiving services at The House Next Door. I understand that I have the right to review the information to be disclosed by this release. If no proper notice of revocation is received, **this consent will expire automatically within 180 days after the date indicated hereon.** A photo copy or fax of this document shall be valid and as effective as the original.

Name of person referring you to The House Next Door: The DCF Investigator from DCF and Paula Grimes from CPC

Put your **initials** by the one agency with which we may exchange information:

_____ Community Partnership for Children Case Manager & Phone: _____
_____ Dept. of Children & Families Case Manager & Phone: _____
_____ Stewart-Marchman / ACT Case Manager & Phone: _____
_____ Attorney Name, Address & Phone: _____
_____ P.O. Name, Address & Phone: _____
_____ Other _____

Put your **initials** by records to be released:

_____ Staffing Reports, Individual Case Plan
_____ Psychological / Educational Reports
_____ Psychological / Psychiatric Tests
_____ Social / Developmental History
_____ Teacher / Parent Observations
_____ Other

NOTE: A SEPARATE RELEASE IS

REQUIRED FOR EACH AGENCY.

☐ By checking the box I certify that I am signing this form electronically and that I have read and understand this form.

_____	_____	_____	_____
Signature of Parent / Guardian	Date Effective	Signature of Witness	Date Effective

HIPPA information sheet and Copy of Release given to client ☐