children & FAMILIES first

CONSENT TO RELEASE and /or RECEIVE CONFIDENTIAL INFORMATION

I, _____

(Print Name of person authorized to give consent: Client, Parent or Guardian)

On behalf of: _____ Date of Birth: _____

(Print name of person to whom information pertains)

Hereby consent to and authorize Children & Families First to (yes or no box **must be checked** for each item)

Receive from **(yes ☐ no ☐):** **and /or** ***Release to*** **(yes ☐ no ☐):**

_____

_____

(Name & Address of Program or Individual)

(Please check yes or no for each item—*do not leave both boxes empty*)

Yes	No		Yes	No		Yes	No	
☐	☐	**Enrollment**	☐	☐	**Treatment/Service Plan**	☐	☐	**Progress Reports**
☐	☐	**Lab Results**	☐	☐	**Medications**	☐	☐	**Substance Abuse**
☐	☐	**Assessment**	☐	☐	**Status/Attendance**	☐	☐	**HIV**
☐	☐	**Diagnosis**	☐	☐	**Discharge Information**			
☐	☐	**Other medical Information**	☐	☐	**Other: (Please specify)** _____			

Specify any limitations on release such as dates of service/treatment: _____

Federal and Delaware State law provide special protections for the release of substance abuse, HIV or other health related information. (Ref: 42 CFR, 45 CFR, DE Title 16)

This information will be used ONLY for the following reasons: (Please check either Yes or No—do not leave both boxes blank)

Yes	No	
☐	☐	To coordinate treatment with my primary care physician and/or my managed care organization (insurance company)
☐	❑	Plan for & provide referral, assessment, ongoing treatment or services, and/or medical care
☐	❑	To obtain insurance, employment, social services or government benefits
☐	☐	To enable judges, attorneys, and/or probation/parole officers to support treatment or services, or make legal decisions on my behalf
☐	❑	To coordinate treatment or services with my family/concerned persons
☐	❑	To coordinate treatment or services with my school, employer and/or EAP representative
☐	❑	Other: (Specify) _____

I understand that by law, I do not need to consent to this release of information. I do so willingly and voluntarily for the purpose(s) specified above**.** I can withdraw this consent at any time except to the extent that action has already been taken. I understand that I am entitled to a copy of this document in completed form. **I certify that this document has been explained to me and that I understand its contents and have checked either "yes" or "no in each of the boxes.** If not previously withdrawn, this consent expires on: _____(not to exceed 90 days from date of signature for one-time release of information; not to exceed one year for ongoing review by a contracted or cooperating service provider).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For information, please contact:

	ADDRESS	*PHONE NUMBER*	*PROGRAM NAME*	*PROGRAM FAX #:*
☐	809 Washington Street, Wilmington, DE 19801	(302) 658-5177	_____	_____
☐	1213 Old Lancaster Pike, Hockessin, DE 19707	(302) 235-5544	_____	_____
☐	91 Wolf Creek Blvd., Dover DE 19901	(302) 674-8384	_____	_____
☐	410 S. Bedford Street, Georgetown DE 19947	(302) 856-2388	_____	_____
☐	400 N. Market St. Ext., Seaford, DE 19973	(302) 629-6996	_____	_____