



**RELEASE OF INFORMATION CONSENT FORM**

I, \_\_\_\_\_, am seeking services from Neighborhood Place for \_\_\_\_\_myself, \_\_\_\_\_my family, \_\_\_\_\_my child (check all that apply). By signing this form, I am giving Neighborhood Place staff permission to communicate regarding services offered to me and/or my family. I understand that all records and information regarding services will be protected by regulations that govern the exchange of confidential information. I further understand that services may include an assessment of our needs and the development of a service plan to meet those needs.

It is understood that by authorizing the release of such information, it will be used for the sole purpose of providing and enhancing services to me, my family and/or my child and to avoid duplication between the agencies. The disclosure of information will be limited to staff at Neighborhood Place and within these organizations and will not be released to anyone else without my consent.

The agencies below have my written consent to share information of a confidential nature to the extent allowed by federal and state law and regulations unless I have indicated otherwise by putting my initials next to those agencies I want excluded.

**Government, City, Private Non-profit Providers**

**Please initial those agencies you want excluded. Write in additional agencies you want *to add*.**

- |  |                                      |
|--|--------------------------------------|
| _____ Louisiana Department of Health & Hospitals | _____ Louisiana Public School System |
| _____ Sabine Parish School System                | _____ Louisiana Workforce Commission |
| _____ Louisiana Department of Social Services    |                                      |
| _____ Louisiana Office of Juvenile Justice       | _____ Other Agencies                 |
| _____ Louisiana Department of Education          |                                      |
| _____ Louisiana City/Parish Government           | _____                                |

**Please initial the information you wish to have excluded from this authorization. Write in information you want to add to this authorization.**

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|---|---|
| ___ The full name and other identification of myself<br>my family or my child                                   | ___ Treatment, services or education plans  |
| ___ Records pertaining to juvenile justice<br>proceedings, including arrests/adjudication                       | ___ Recommendations to other providers  |
| ___ Social and educational history and<br>observations  | ___ Medical records and information pertaining<br>to medical history, physical condition,<br>services rendered and treatments given |
| ___ Records pertaining to child in need of care/<br>certification for adoption proceedings in<br>juvenile court | ___ Medical records and information<br>and information pertaining to mental<br>health   |

Other Records: \_\_\_\_\_

**I have read and understand the contents of this form; I have a copy and I agree to its provisions with the exception of any items I initialed above.**

**This authorization to receive services from the above agencies and to exchange confidential information shall remain in effect for a period of twelve (12) months. I understand that this release may be revoked by me at any time if requested in writing, but understand my records may have been released and re-released to others before I request that this consent be revoked.**

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Signature of self or children	Date	Witness signature	Date
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**\* Parent/Guardian (please list children's names) \_\_\_\_\_**

**THIS DOCUMENT DOES NOT AUTHORIZE THE RELEASE OF INFORMATION RELATIVE TO HISTORY OF DRUG/ALCOHOL TREATMENT, SEXUALLY TRANSMITTED DISEASES, AND/OR HIV STATUS. PURSUANT TO FEDERAL LAW, PROTECTED HEALTH INFORMATION MAY BE RELEASED WITHOUT YOUR AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. AUTHORIZATION IS NOT REQUIRED TO COMPLY WITH LAWS REGARDING MANDATORY REPORTING OF SUSPECTED ABUSE OR NEGLECT OR ASSESSMENT THAT THERE IS A DANGER OF SERIOUS HARM TO SELF OR OTHERS.**