CHARLOTTESVILLE/ALBEMARLE
COMMISSION ON CHILDREN & FAMILIES

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I_____, am signing this form
(Full Printed Name Of Consenting Person or Persons)

on behalf of _____
(Full Printed Name of Client)

_____ _____ _____
(Client's Address) (Client's Date of Birth) (Client's SSN)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian

☐ Other Legally Authorized Representative

I authorize the following confidential information about the client (except drug or alcohol abuse diagnoses or treatment information) to be exchanged by and among the Interagency Network Team. The Interagency Network Team may not release this information to another party, person, agency, etc., without my written authorization:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed Planned and/or Received	☐	☐	Medical Records	☐	☐	Juvenile/Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

It has been explained to me that an Interagency Network Team consists of a professional representative from the Charlottesville/Albemarle Department of Social Services, the Charlottesville/Albemarle Public Schools, the Juvenile Court Service Unit, Region Ten Community Services Board, the Thomas Jefferson Health District, a representative from a private human service agency that serves the needs of children and their families, and a parent representative. Also invited to participate in the presentation of the staffing are any other appropriate community professionals who are closely involved with the child and/or family. The purpose of the staffing is to share the above confidential information and resources in order to develop specific recommendations to best serve the needs of the child.

I want this information to be exchanged ONLY for the following purpose(s):

☐ Treatment Planning & Coordination ☐ Eligibility Determination for Services

Other (write in): _____

Date upon which this consent expires: _____
(One year from date of Parent/Guardian signature)

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. I also direct and request that the professional representatives accept a photocopy of this release as a valid authorization to release such information.

Signature(s): _____ _____ Date: _____
Parent/Guardian Parent/Guardian

Signature: _____ Date: _____
Client (if appropriate)

Witness: _____ _____ _____
(Signature) (Title) (Phone Number)