

COORDINATED CHILDREN'S SERVICES INITIATIVE
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Child: _____

Address and Telephone Number of Child: _____

Name of Parent Signing Consent: _____

School District and School: _____

Name of County or City of New York: _____

Issuing Office: _____

Address and Telephone Number of Issuing Office: _____

Starting Date of Consent: _____

Ending Date of Consent: _____

PURPOSE

The Coordinated Children's Services Initiative was established to insure that families are supported in staying together, and that children remain at home and in their communities, by improving the quality of decision making for children with emotional and behavioral disturbances through State and local interagency partnerships. An essential component of the Initiative is the establishment of a local service planning team which accepts referrals, compiles assessment and referral materials, and develops, coordinates and implements individualized service plans for children and their families.

I understand that it may be necessary for the members of the team to exchange confidential information relating to my child and our family, and to obtain information, from other individuals, organizations and agencies that have provided services to my child and our family in order to develop appropriate service plans. The purpose of this form is to obtain informed consent for the disclosure of confidential information necessary to address the needs of my child and our family.

Information which is disclosed pursuant to this Consent will be kept confidential by the Information Recipients, will not be re-disclosed to any other person, agency or organization by the Information Recipients, and will not become part of the internal records of the government agencies represented on the Coordinated Children's Services Initiative team, pursuant to Mental Health Law 33.13(f).

INFORMATION SOURCES: The information identified below, to the extent it is relevant to the purposes of the Coordinated Children's Services Initiative, may be released under this consent by the following government agencies, medical professionals or facilities, or other organizations or individuals (please list any agencies, organizations or individuals that may have information relevant to the purposes of the Coordinated Children's Services Initiative, and provide an address, telephone number or other means of contacting each. Using the Guide to Services and Providers or your own recollection of services that have been made available to your child or family, please list the categories of information which may be released under this consent).

Name of Information Source: _____

Information to be released: _____

(attach additional sheets as necessary)

INFORMATION RECIPIENTS: Information may be provided pursuant to this Consent to the agencies which are members of the Coordinated Children's Services Initiative; which may include representatives of the county department of social services, New York city administration for children services, the county or city department of mental health, the local youth bureau, the school or school district attended by the child, the county or city probation department, the New York State Office of Mental Health, and the New York State Office of Children and Family Services.

In addition, information may be released to the following services providers which have been identified in the services plan developed for my child and our family pursuant to the Coordinated Children's Services Initiative:

Name of Service Provider: _____

Address: _____

(attach additional sheets as necessary)

**CONSENT TO DISCLOSURE OF ALCOHOLISM OR SUBSTANCE ABUSE
TREATMENT INFORMATION:**

I, _____ as the child who is the subject of a Coordinated Children's Services Initiative assessment, authorize _____ to release the following alcoholism and drug abuse treatment information to the members of the Coordinated Children's Services Initiative interagency team for the purposes set forth above (be as specific as possible; attach additional sheets as necessary): _____

This consent will expire at the time specified in the above General Consent. I understand that my alcoholism and substance abuse treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Substance Abuse Patient Records (42 C.F.R. Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

(Signature Of Child)

(Date)

(Signature of Parent or Guardian, if required)

(Date)