ChildSafe Colorado, Inc.

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL TREATMENT INFORMATION

_____ _____

Myself or Name of Child Date of Birth

I hereby authorize ChildSafe therapists to disclose and/or receive confidential information concerning me and/or my child, including medical records, treatment notes, evaluations, and reports or records of other treatment providers concerning me and/or my child. I authorize ChildSafe to disclose confidential information concerning me or my child verbally and in writing concerning my case. I authorize ChildSafe to use professional judgment in deciding what specific information will be released and communicated, and to use professional judgment in deciding whether specific records or a summary of treatment information should be disclosed. I authorize the exchange of information with the following agencies and/or individuals:

Please Initial:

_____ Department of Human Services (specify County) _____

_____ Summitstone Health Partners

_____ School Staff (specify school(s)) _____

_____ Law Enforcement Agency (specify) _____

_____ Victim's Compensation Program (specify County) _____

_____ District Attorney's Office (specify County) _____

_____ Probation Office (specify County) _____

_____ Child Advocacy Center (specify County) _____

_____ ChildSafe Therapists (Required)

_____ Medical Professional _____

Others _____

_____

_____

Disclosure Regarding Confidentiality of Treatment Information

I understand that any treatment records concerning my mental health treatment or assessments are confidential under Colorado law, and that a statutory privilege prohibits confidential treatment information from being disclosed without my consent.

This release authorizes the disclosure/exchange of information between ChildSafe staff and the persons or agencies identified above. The persons or agencies receiving this information may not share such information with any other person or agency without obtaining my written consent.

I understand that I have no obligation to sign this authorization for the disclosure of confidential information about myself and/or my child. In addition, **I understand that I may revoke this consent for disclosure of information in writing at any time.** This consent expires automatically as follows:

Thirty days past client's termination from services (to allow for termination summary to be completed and any after-care plans to be coordinated)

If you would like to specify a date, event, or condition upon which consent expires: _____

_____ _____ _____

Printed name of client or legal guardian **Signature** **Date**

_____

Relationship to child (if applicable)

June 2017