R.E.A.C.H. Located at FASD Elementary School 100 Dartmouth Ave. Phone: 814-535-6724 ext 4108

CONSENT TO RELEASE INFORMATION Active for the 2022-2023 School Year

Child's Name: _____

Date of Birth: _____

Grade/Homeroom Teacher:

I hereby authorize the Ferndale Area School District to release and receive confidential information on the above-named child under the following terms:

Parent/Guardian initial to indicate consent:

_____ location of student in the FASD Building

_____ release information from FASD to R.E.A.C.H.

release information from R.E.A.C.H. to FASD

Information will be shared for the sole purpose of coordination of care efforts between FASD and R.E.A.C.H.

Shared information may include, but is not limited to the following:

Location of student in FASD building, educational information, verbal communication about mental health services, school-based concerns, written summary of progress.

*I understand that I may refuse to sign or revoke this authorization at any time without it affecting my child's ability to obtain services.

*Release must be given for location of child to be shared between FASD and R.E.A.C.H. for services to be provided.

Signature of Parent or Legal Guardian

Date

Limits of Confidentiality in Ferndale Area School District

- 1. If an individual discloses <u>Suicidal Thoughts with suicidal plans</u>, Intent, means
- 2. If an individual reports Child Abuse or Child Neglect
- 3. Report of immediate Self-Harm Behaviors or plans to harm self
- 4. Specific <u>plans of violence</u> toward others: Verbalized or Expressed <u>Intent to harm others</u>

5. <u>Current Drug or Alcohol Use</u> if client displays visible impairment or discloses use in the school setting

6. Upon receipt of a legitimate subpoena or court order

I understand that all professional efforts will be made to ensure the Client's Protected Health Information will be kept secure following HIPAA guidelines and only released under terms above or with signed release of information by client over 14 years of age or Parent/Guardian if under 14 years of age. By signing below, I understand and agree to the terms of confidentiality and HIPAA compliance.

Client Signature	Date

Parent/Guardian Signature

Date

By initialing, I am giving permission to use the following forms of communication to be contacted by therapist throughout treatment. I understand confidentiality cannot be ensured completely through texting, email, or communication notebook. However, every attempt will be made by therapist or staff to ensure confidentiality is maintained.

Phone:		_Call or Text		
	Primary Phone number		Parent/Guardian Name	
Phone:		_Call orText		
	Primary Phone Number		Parent/Guardian Name	
Email:				
	Email address		Parent/Guardian Name	
Communication notebook sent back and forth from school to home				
Client Na	ame:	DOB:	DOS:	