NEIGHBORHOOD PLACE 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 written consent.

The agencies below have my written consent to share information of a confidential nature unless I have indicated otherwise by putting my initials next to those agencies I want excluded.

Government or Private Non-profit Providers

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

_____ Ky. Cabinet for Families and Children - Division of Protection and Permanency
_____ Ky. Cabinet for Families and Children - Division of Family Support
_____ Louisville/Jefferson County Metro Human Services
_____ Louisville/Jefferson County Metro Health Department
_____ Jefferson County Public Schools
_____ Seven Counties Services, Inc.
_____ Other:
_____
_____
_____

(Please initial the information you wish to have* excluded *from this authorization. Please* write in *information you wish to add to this authorization.)

_____ The full name and other identification of myself, my family or my child
_____ Records pertaining to juvenile justice proceedings, including arrests/adjudication
_____ Social and educational history and observations
_____ Records pertaining to dependency proceedings in juvenile court
_____ Treatment, service or education plans
_____ Recommendations to other providers
_____ Medical records and information pertaining to medical history, physical condition, services rendered and treatments given
_____ Medical records and information pertaining to mental health
_____ HANDS records
_____ Other:
_____
_____

I have read and understand the contents of this form; I have received 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.

_____ _____ _____ _____
Signature for self or children Date Witness Signature Date

_____
Parents/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.