LIVINGSTON COUNTY
CHILDREN'S NETWORK

Exchange of Mental Health, Medical, Legal and/or Educational Information

Name: _____ **Birth Date:** _____

I am allowing these providers to communicate and exchange information for the purpose of:
☐ **Coordinating Services** ☐ **Assisting in Treatment** ☐ **Assessing treatment effectiveness**

If I check the box, I consent to information exchange with that provider. I have provided the name and number of a contact person where possible:

☐ **School District** _____
☐ **LCCN Database** _____
☐ **Medical Provider** _____
☐ **Resource Link** _____
☐ Institute for Human Resources _____
☐ LC Mental Health Board _____
☐ Commission on Children & Youth____
☐ Boys & Girls Club_____
☐ Police Dept_____
☐ **Livingston County Special Services Unit**_____
☐ **Child & Family Connections**_____
☐ **OSF Early Intervention Program**_____
☐ Head Start _____
☐ LC Health Department _____
☐ Probation/Court Services_____
☐ Dept of Children & Family Services_____
☐ A Domestic Violence/Sexual Assault Service_____
☐ Other_____

Nature of Information:

☐ **Verbal Communication**	☐ Diagnosis	☐ Intake Summary	☐ **Screening Data**
☐ Referral Paperwork	☐ Attendance	☐ Recommendations	☐ Medical History
☐ Classroom Observations	☐ Social History	☐ Hg/Lead Labs	☐ Developmental History
☐ Psychiatric Consultations	☐ Medications	☐ School Records	☐ Academic Reports
☐ Psychological Evaluations	☐ AIDS/HIV	☐ Genetic Testing	☐ Discipline Record
☐ Emergency Dept Records	☐ Prognosis	☐ Treatment Plan	☐ Discharge Summary
☐ Sexual abuse/assault Records	☐ Legal Records	☐ Court Service Reports	☐ Substance Abuse
	☐ Other_____		☐ Progress Notes

MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION THAT FOLLOWS. I understand:

1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at anytime upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent automatically expires one year from date of signature or on _____ whichever is earlier.
4. That I have the right to inspect or copy information to be released.
5. That failure to consent to such a release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other entity without my specific written consent.

EFFECT OF GRANTING THIS AUTHORIZATION: The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and federal health information privacy laws may no longer protect it. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to your authorization.

I am willing that a reproduction of this consent be accepted with the same authority of the original.

SIGNATURE OF CLIENT*: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____ WITNESS: _____ AGENCY: _____

Dear Parent or Guardian,

I am a member of **Livingston County Children's Network** which is made up of all the groups listed on the back of this page. We are working together to support all parents in Livingston County as they raise their children to be happy, healthy, and successful citizens. We have come to realize that it is becoming harder and harder for families to do this because of all of the stress we and our children are facing in the world today. We are eager to get to know your child and want to be able to offer whatever kinds of support might be helpful to him or her over the next year. In order for us to talk about the needs of your child and all the possible resources which might be available, we need to ask your consent to communicate with one another. You can give us permission by checking the boxes next to the different team members.

You also have the opportunity to indicate the kinds of information you would like for us to share. If you check the "personal communication" box, that means we can discuss your child's needs and progress and coordinate opportunities for him or her. If you wish, you can also instruct us to share various documents by checking the boxes provided. This form allows us to exchange information for a year, but you can change your mind about any part of it whenever you want.

Thanks for giving us the opportunity to get to know your child and allowing us to partner with you in fostering healthy development! We hope you will share with your family and friends our vision...

"Families across Livingston County will utilize and value a comprehensive continuum of services to promote children's social and emotional development which will, in turn, effectively reduce at-risk behaviors and strengthen relationships."

Parent/Guardian Name(s): _____
Address: _____
Phone Number(s): _____
E-mail: _____
Medicaid Number/ Insurance Provider & Number _____