



**TEHAMA COUNTY SYSTEM OF CARE (Form #1)  
Consent for Release of Confidential Information and/or Records  
To the Multidisciplinary Services Team**

This consent authorizes the gathering, exchange and release of information and/or records for integrated children's services programs, as defined and provided for in Section 18986.46, et seq., of the Calif. Welfare & Institutions Code, for purposes of developing a plan of comprehensive services and making appropriate referrals for children and their families within the Children's System of Care program.

I, \_\_\_\_\_, as the (parent, guardian or legally authorized representative) of \_\_\_\_\_ hereby authorize the release and exchange of confidential information and/or records to and among members of the multidisciplinary team for the specific purpose of formulating, providing, and verifying and coordinating service plans for the above-named child, the minor family members listed below, and myself.

Name: _____	My relationship to them: _____
Name: _____	My relationship to them: _____
Name: _____	My relationship to them: _____
Name: _____	My relationship to them: _____
Name: _____	My relationship to them: _____

(Please print name of person above, whose information and/or records are released (including the signing adult), the familial relationship of the adult signing this release to the person listed, and whether the adult signing is the listed person's parent, guardian, or legally authorized representative).

**I understand that the participating agencies making up the multi-disciplinary services team include the following:**

- |                                                                    |                                                                                 |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input type="checkbox"/> <u>TEHAMA COUNTY HEALTH AGENCY</u>        | <input type="checkbox"/> <u>SCHOOL DISTRICT</u> of Minor Child and/or Potential |
| <input type="checkbox"/> Drug & Alcohol Division                   | <input type="checkbox"/> School District of Minor Children's attendance         |
| <input type="checkbox"/> Mental Health Division                    |                                                                                 |
| <input type="checkbox"/> Public Health Division                    | <input type="checkbox"/> <u>NORTHERN VALLEY CATHOLIC SOCIAL SERVICES</u>        |
| <input type="checkbox"/> <u>TEHAMA CO. PROBATION DEPARTMENT</u>    | <input type="checkbox"/> <u>LEARNING CENTER OF TEHAMA COUNTY</u>                |
| <input type="checkbox"/> <u>TEHAMA CO. DEPT OF SOCIAL SERVICES</u> | <input type="checkbox"/> <u>CENTER FOR EVALUATION &amp; RESEARCH (CER)</u>      |
| <input type="checkbox"/> Child Protective Services Division        | <input type="checkbox"/> <u>OTHER</u>                                           |
| <input type="checkbox"/> Adult Protective Services Division        | <input type="checkbox"/> <u>OTHER</u>                                           |
| <input type="checkbox"/> Cal Works Services                        | <input type="checkbox"/> <u>OTHER</u>                                           |
| <input type="checkbox"/> <u>TEHAMA CO. DEPT. OF EDUCATION</u>      |                                                                                 |

**I hereby authorize the agencies I have initialed above to view, copy, release, and exchange the following (as selected by initialization) information and/or records via oral conversations, written reports, and/or electronic transmission:**

- |                                                                                                                                         |                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Summary of related medical, psychiatric, developmental, educational, drug and alcohol, psychosocial histories. | <input type="checkbox"/> Service treatment plans.                                                                             |
| <input type="checkbox"/> Medical diagnosis, assessment, and evaluation.                                                                 | <input type="checkbox"/> Information in the System of Care electronic database system.                                        |
| <input type="checkbox"/> Psychiatric diagnosis, assessment, and evaluation.                                                             | <input type="checkbox"/> Information contained in the school confidential file.                                               |
| <input type="checkbox"/> Drug and/or alcohol abuse.                                                                                     | <input type="checkbox"/> Information contained in the school cumulative file.                                                 |
| <input type="checkbox"/> Toxicology screens.                                                                                            | <input type="checkbox"/> Educational assessment and behavioral reports, including school observation and educational testing. |
|                                                                                                                                         | <input type="checkbox"/> Other _____                                                                                          |

I understand that my records are protected under State and Federal confidentiality statutes/regulations and cannot be disclosed without my written consent, unless otherwise provided for in the statutes/regulations. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, and that in any event **THIS AUTHORIZATION EXPIRES AUTOMATICALLY ONE YEAR AFTER THIS DATE.**

Client confidentiality will be maintained according to the California Education Code, Section 46069; California Welfare & Institutions Code, Sections: 4514, 5328 and 10850, 42 CFR, Part 2, Drug/Alcohol Code. All children 12 years of age and older must give informed consent to release drug/alcohol records.

**I UNDERSTAND THAT, NOTWITHSTANDING THEIR PARTICIPATION IN THE MULTI-DISCIPLINARY SERVICES TEAM, SOME EMPLOYEES OF THE PARTICIPATING AGENCIES HAVE A PRE-EXISTING DUTY AS MANDATORY REPORTERS TO RELEASE CONFIDENTIAL INFORMATION; THEIR DUTY REMAINS WHOLLY UNAFFECTED BY PARTICIPATION IN THE MULTIDISCIPLINARY SERVICES TEAM.**

I specifically understand that:

1. If the client's child care custodian possesses a reasonable suspicion that the client has been abused, then he/she is a mandated reporter as provided in Penal Code Section 11166 and is required to report the same to the Child Protective Services Agency and/or the Law Enforcement Agency as appropriate.
2. If the client, in the opinion of the client's psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims as provided in Subdivision (r) of Section 5238 of the Welfare & Institutions Code, then both the person(s) and law enforcement will be notified by the psychotherapist.

**THE OBLIGATIONS OF MANDATORY REPORTERS ARE NEITHER VITIATED BY THIS RELEASE NOR THE PARTICIPATION OF SUCH MANDATORY REPORTERS IN THIS MULTI-DISCIPLINARY SERVICES TEAM.**

Every member of the multidisciplinary service team who receives information or records on the client serviced is under the same privacy and confidentiality penalties as the person disclosing or providing the information or records. The information or records obtained pursuant to the authorization shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights.

**I release the participating agencies and employees of the participating agencies listed above from any and all liability arising from this release of records and/or information.**

**I hereby acknowledge receipt of a photo copy of this authorization.**

Client signature: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Staff member signature: \_\_\_\_\_

Date Executed: \_\_\_\_\_

At: City: \_\_\_\_\_ Co. \_\_\_\_\_ State \_\_\_\_\_