LASSEN LINKS
Helping You Connect

Consent for Release of Information & Authorization to refer to Community Resources

In order to provide better services to you and your family, this program would like your permission to connect you with other community resources that may be available to you. By signing this consent form, you allow us to provide you with the best possible service by sharing your information with the Lassen County Home Visiting Collaborative.

Servicing Agency Information:

Name of Program: _____

Name of Representative from Program: _____

Client Information:

Last Name: _____ First Name: _____ Middle Initial _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____)_____ Date of Birth: _____

Legal Status: ☐ Minor with Parent or legal guardian ☐ Ward of Juvenile Court

Does parent retain educational rights? _____ If not, who does? _____

I authorize the following programs to share my information so that I can receive better service. (Please initial the programs you authorize).

☐ Lassen County Office of Education
☐ Public Health Department
☐ Lassen WORKS
☐ Lassen Oral Health Program
☐ Pathways to Child & Family Excellence
☐ Sierra Cascade Family Opportunities
☐ Women Infant Child
☐ Wrap Around
☐ Lassen Intervention
☐ Lassen Wellness Center

☐ Northeastern Rural Health Clinics
☐ Lassen Indian Health Center
☐ Acorns to Oak Trees
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

You will know in advance when we are making a referral on your behalf. Our program will only voluntarily release your name, phone number, address, and family needs/family plan to the community partners named above. Medical information, financial information and social history are only released to providers who are directly linked to those services. To protect your confidentiality, your information will not be shared with non-essential persons and will be stored in a secure area.

Purpose/Limitation of requested use or disclosure (initial).

☐Client Request ☐Continuum of Care ☐Limitation ☐Other

Please describe limitations/other if initialed:

_____

This authorization shall remain effective until ____/____/_____ or until revoked in writing prior to that date (not to exceed two years).

I understand that I have a right to receive a copy of this authorization upon request. A copy of this authorization (has /has not) been requested. A photocopy of this authorization is as valid as the original.

I understand I have the right to revoke this authorization. I understand if I revoke this authorization, I may do so in writing and submit it to the following address, or I may request assistance where I receive services:

Ronda Hall - 1445 Paul Bunyan Rd, Susanville, CA 96130 - RHall@co.lassen.ca.us

I understand the revocation will not apply to information already released based on this authorization. If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be re-disclosed and no longer protected, but any alcohol and/or drug treatment records cannot be re-disclosed without my written consent unless otherwise provided for by 42 CFR Part 2 and 45 CFR parts 160 and 164. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment or payment, enrollment, or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed. I have the right to receive a copy of this authorization.

Signature of Client or Legal Representative

I hereby authorize the use and disclosure of my information in accordance with the information entered above for the purposes described in this form. I understand this does not authorize the recipient of this disclosed information to further use or disclose this information, except as allowed or required by law. I further understand information released then becomes the responsibility of the recipient and is no longer under the protection of the releasing entity.

_____	_____	_____
Print Name	Signature of Parent or Guardian	Date
_____	_____	_____
Witness	Title/Department	Date