RELEASE OF INFORMED CONSENT

BRICKHOUSE FAMILY MINISTRIES
RESTORING TEENS • REBUILDING FAMILIES

Clients Name:_____

Address:_____

City: _____ **St:** _____ **Zip:** _____

Phone:_____ **DOB:**_____

I, _____, authorize Alicia Hill, Executive Director and/or Adam Carroll, Pastoral Counselor and/or Penny Cole, Teacher and/or Kevin Fiechter, Home-Based Services Coordinator at BrickHouse Family Ministries, Inc. to: ___ (send) OR ___ (receive) the following ___ (to) OR ___ (from)

Name: _____

Address: _____ City: _____ State: _____ Zip: ___ _____

Phone: _____ Fax: _____

____ Academic testing results
____ Individualized Education Plan
____ Service plans
____ Progress reports
____ Intelligence testing results
____ Medical reports
____ Psychological testing results
____ Personality profiles
____ Psychological reports
____ Summary reports
____ Other, specify: _____
____ Other, specify: _____

The above information will be used for the following purposes:

____ Planning appropriate treatment
____ Determining eligibility for placement
____ Continuing appropriate treatment
____ Case review
____ Other, specify: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ___ Parent ___ Legal guardian ___ Other: _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____
Parent/Guardian/Other Signature Date

This release of informed consent expires at end of the client's treatment