Consent to Release Information Montgomery County Collaboration Council

To Families: We can help you better if we are able to work with other agencies that may know your child and family. By signing this form, you are giving permission for these agencies to share information about your child. You will not be denied services for which you are otherwise eligible if you choose not to sign this form

Section I.	Identification of Child

Childs Name: _____ Date of Birth: _____
(Please print)

Section II.	Consent of Authorized Person to Release Information Among Public Agencies

I understand that the purpose of this authorization is to allow agencies to share information and records in order to plan and provide services to the above child in a coordinated and effective way. I agree that the agencies listed below may share and exchange information about my child. I understand that information exchanged under this authorization is confidential. I understand that this authorization expires automatically one year after signing unless otherwise stated below, but may be revoked by me in writing at any time except to the extent that information has already been released with this authorization.

I, _____, on _____ authorize the release of information
(parent/guardian name: **Please Print**) (date)
and records on the above child by the following public agencies. Copies of this form to one or more of the agencies listed below.

☒ Montgomery County Health and Human Services
☒ Montgomery County Public School System
☒ Montgomery County Substance Abuse
☒ Montgomery County Collaboration Council CWIN Team
☒ Federation of Families (Family Navigation)
☒ Maryland Department of Health and Mental Hygiene
☒ Maryland Department of Juvenile Services
☒ Maryland Developmental Disabilities Administration
☒ Maryland Choices
☒ YMCA
☒ Other agency/facility/doctors/schools that can give information to help the child:
_____

Information Being Requested (check all that apply):

☐ Reports or records concerning child's psychological or cognitive abilities
☐ Early intervention reports or records
☐ Recommendation for intervention or treatment
☐ Assessment of child's family situation
☐ Relevant financial and insurance information
☐ Educational reports or records
☐ Child's medical health needs/treatment/history
☐ Child's mental health needs/treatment/history
☐ Alcohol/drug treatment (Specifically identify information authorized to share)

_____

☒ Other (specify any information to help in planning for the child)

_____

Purpose of Request: For LCT to plan for appropriate services in order to maintain child/youth in the least restrictive environment

Parent/Guardian Authorization Signature: _____

Revised: 9/28/2015