**Our House of Hope**

**Community-Based Residential Program**

**Client Consent to Share Information with External Providers and Agencies**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE**

This form authorizes staff at Our House of Hope Community-Based Residential Program to share relevant information regarding the client’s care, progress, and areas of concern with designated healthcare professionals, therapy providers, day program staff, and social service agencies who are involved in the client's support and wellbeing.

**TYPES OF PROVIDERS/AGENCIES COVERED BY THIS CONSENT**

(Staff may communicate with the following external parties):

* Medical Doctors (MDs)
* Nurse Practitioners (NPs)
* Psychiatrists and Psychologists
* Therapists (Occupational, Physical, Speech, Behavioral, etc.)
* Day Programs or Vocational Training Providers
* Social Workers and Case Managers
* County or State Social Service Agencies
* Community Support Providers
* Emergency Services if needed for health or safety

**TYPES OF INFORMATION TO BE SHARED**

(Information shared may include, but is not limited to):

* Health and medical updates, medication management, and treatment plans
* Behavioral and emotional status
* Progress toward goals in care or therapy
* Participation and performance in day programs
* Safety concerns or behavioral incidents

**TYPES OF INFORMATION TO BE SHARED(Continued)**

* Discharge planning or transitions
* Coordination of care and case management

**METHODS OF COMMUNICATION**

☐ Phone

☐ Text Message

☐ Email

☐ Fax

☐ In-Person Meetings

**Note**: Email and text communications are not fully secure. By selecting these options, you acknowledge and accept the risks associated with electronic communication.

**CONSENT AGREEMENT**

I, the undersigned, hereby give permission to Our House of Hope staff to share relevant information about my care and progress with the individuals and agencies listed above, for the purposes of treatment coordination, health and safety, and ongoing support. I understand:

* This consent is voluntary and can be revoked at any time in writing.
* This release remains in effect for the duration of my participation in the program, unless revoked.
* The information shared will be limited to what is necessary to coordinate services and support my care.
* My privacy and confidentiality are protected under applicable state and federal laws, including HIPAA.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

(or legal guardian if client is unable to consent)

Printed Name of Guardian (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Revocation of Consent (Optional - to be completed only if withdrawing permission)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby revoke this consent effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Client or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_