**THE UTAH HOUSE**  
*A Family-Centered Mental Health Program*  
Website: [www.theuthouse.com](http://www.theuthouse.com)  
Phone: 801-678-3317

Address:

331 W 2700 S

Salt Lake City, UT 84115

**Introduction**

The Utah House is a community-based mental health agency providing trauma-informed therapeutic services for youth and families. Our goal is to support healing, stability, and resilience through structured clinical interventions, family support, and community collaboration. We are honored to collaborate with Utah’s Children’s Justice Centers to improve access to quality care for children and families impacted by trauma.

**AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION**

**Between:**

**The Utah House** & Utah **Children’s Justice Center (CJC)**

**Client Information:**

* **Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_
* **Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure:**

To coordinate care, share assessment and treatment information, develop safety or service plans, and ensure continuity of support for the client and family.

**Information to be Disclosed (check all that apply):**

☐ Diagnosis and clinical impressions  
☐ Treatment plans and progress updates  
☐ Attendance and engagement in services  
☐ Assessment reports or evaluations  
☐ School or academic reports related to treatment  
☐ DCFS or legal documentation as applicable  
☐ Coordination and planning with court or allied professionals  
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This release allows:**

☐ Two-way communication between both parties  
☐ Verbal communication only  
☐ Written records only

**Expiration of Release:**

This authorization will remain in effect for:  
☐ One year from the date of signature  
☐ Until the following date/event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
☐ Until revoked in writing

**Your Rights:**

* You may revoke this authorization at any time by submitting a written request.
* Refusing to sign this form does not affect your ability to receive care.
* Information shared under this release may not be further disclosed without your written permission, unless required by law.

**Signature of Client (if age 18+):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_  
**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_  
**Relationship to Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness (if needed):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

***CJC Referral Application Form for Services:***

**Client Information**

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

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** ☐ Male ☐ Female ☐ Other: \_\_\_\_\_\_\_\_\_\_\_

**Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary insurance or funding source:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary insurance ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Primary Insured:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there secondary insurance coverage or another funding source:** \_\_\_\_ YES \_\_\_\_\_ No

**Referral Source (CJC Representative)**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services Requested:**

☐ Individual Therapy  
☐ Family Therapy  
☐ Parenting Support  
☐ In-home services (as needed and available)  
☐ Coordination with DCFS/Court/School  
☐ Transportation Required

**Additional Notes or Concerns:**

Please email this form to [Intake@theuthouse.com](mailto:Intake@theuthouse.com)

A team member from The Utah House will reach out to the family within 1–2 business days.