

Community and Family Services, LLC

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), give my consent for the use and disclosure of the following information about me or my child(ren) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

**Information to be used and disclosed:**

Reports and documents about myself and my family, including social services case history and plans, information from professionals (treatment plans and doctor reports), school information (educational plans and attendance reports), police reports and letters or reports from family members.

**For the following purpose(s):**

This information will be used for planning, coordinating, and facilitating my Family Group Decision Making (FGDM) meeting to develop a family plan for my child(ren) and our family.

**I authorize the following persons to exchange, release or disclose this information:**

(You may want to include extended family members, close friends, social service case worker, mental health therapists, school counselors or special education staff, mentors, guardian ad litem, foster care providers, tribal representatives, etc.). Please provide as much contact information as possible.

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| --- | --- | --- | --- |
| **Name** | **Email** | **Phone** | **Relationship** |
| Community and Family Services |  |  | Coordinator/Facilitator |
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| **I also authorize CFS to contact the above persons to contact, share goals and process of the FGDM meeting** | **Parent(s)/Legal Guardian**  **Signature:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Parent(s)/Legal Guardian**  **Signature:**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Please list above: if you are a family member your relationship to the child(ren) and if a service provider your role in working with the family |

I understand that a copy of the Family Plan that we create during the FGDM meeting will be distributed to all participants.

I understand that state and federal laws protect this information. With my consent, this information could be shared with agencies or businesses who may not be covered by these laws. They could share this information with others.

I understand I may revoke my consent in writing at any time; but this will not affect data already disclosed. This consent will automatically expire one year from the date of my signature. A photocopy of this consent may be treated in the same manner as the original.

I do not have to sign this consent. I understand my ability to obtain services will not depend in any way on whether I sign this consent or not. But refusing to consent could affect the agency’s ability to determine what services I need or qualify to receive.

**Name(s) Printed** **Signature(s)** **Date**

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