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Sampson County CAC

204 Sampson Street, Clinton, NC 28328

910-490-9100

**Authorization for Release of Information**

**Name of Child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Last Name First Name M.I.

Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MM/DD/YYYY

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have authority to consent to the release of confidential and privileged information of the above-named minor child as:

|  |  |
| --- | --- |
| \_\_\_\_ | The child’s parent |
| \_\_\_\_ | The child’s legal guardian or custodian |

In order to provide for the best care and protection of the children in our community, the Sampson County CAC collaborates with a multi-disciplinary team (MDT) made up of medical providers, the Department of Social Services, law enforcement, prosecutors, mental health providers, victim advocates and others. The purpose of this release is to facilitate the sharing of information by the agencies participating in the MDT in order to provide for the best treatment and protection of the child named above.

I hereby authorize the Sampson County CAC to release/exchange information pertaining to suspected physical or sexual abuse and/or neglect obtained during the medical evaluation, forensic interview or Child/Family Evaluation that may facilitate the diagnosis, treatment, investigation and/or court intervention of child maltreatment to the agencies, organizations and individuals named below and initialed by me. It may also be used for training and education. I understand that this may include information regarding drug/alcohol abuse, sickle cell anemia, abortion, genetics, tuberculosis, psychological and psychiatric conditions, sexually transmitted diseases, including HIV/AIDS, domestic violence and issues involving abuse and neglect. This may include pictures, recordings and video, which may be used to document the assessment.

I understand that there are laws requiring Sampson County CAC to release/report information to the Department of Social Services and appropriate Law Enforcement agencies where child abuse and neglect is suspected.

I also understand that Sampson County CAC may release the child’s medical information to any licensed provider or medical facility to which he or she may be referred for further medical care.

I hereby authorize Sampson County CAC to release confidential and/or privileged information of the child named above to the following:

 Initials Initials

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_ | Law Enforcement Agencies | Name: | Therapist/Psychiatrist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | District Attorney/Prosecutor | Name: | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | Members of the Multi-Disciplinary Team listed in the attached Administrative Order | Name: | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This consent to release information has been explained to me and I understand the information which may be released/exchanged, the need for the information and that there are statutes and regulations protecting the confidentiality of some or all of the information subject to this release. I understand that once certain health information is released, the recipient may disclose or share the information with others and it may no longer be protected by federal and/or state privacy protections.

I understand that my decision to sign this authorization will not affect the treatment provided to the child named above in any way.

I understand that this consent will be valid from the date of my signature below and will expire upon resolution of the case as determined by the MDT. I further understand that I may revoke this consent at any time by notifying Sampson County CAC in writing, except to the extent that information has already been disclosed based on this consent or continued disclosure is required by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Person Authorized to Consent Relationship to Child Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Date