RELEASE OF INFORMATION

To Our Clients: We can help you better if we are able to work with the other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

Douglas *CARES*
545 W Umpqua St, Roseburg, OR 97471
(541) 957-5646 FAX (541) 957-0191

Parent/Guardian Name: ____ D.O.B. __________________

Child: ____ D.O.B. __________________

I authorize the following individuals or agencies (All unless crossed out):

District Attorney's Office	Multidisciplinary Child Abuse Team
Children's Services Division	Juvenile Department
Law Enforcement	Family Development Center
Mercy Medical Center	Medical Providers
Primary Care Physician	Insurance Provider
Other: ___________________________	

To provide to, and exchange information with:

Douglas CARES 545 W Umpqua St, Roseburg, OR 97471

I authorize the following information to be provided and exchanged:

☐ Yes ☐ No Family History

☐ Yes ☐ No Educational Reports

☐ Yes ☐ No Mental Health Services

☐ Yes ☐ No Medical/Psychiatric Treatment

☐ Other, as listed:

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I understand that mental health and medical records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

☐ Yes ☐ No I agree that the agencies and individuals listed above may share and exchange information/copies of reports about my family and my circumstances.

☐ Yes ☐ No If CARES does a medical exam of your child; the examining physician at CARES may be consulting with other physicians and is authorized to seek consultation via telemedicine.

Purpose: The information received will be used for an abuse assessment and to plan for and coordinate services for me and my family.

This permission is good for one year or until withdrawn.

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

☐ Client ☐ Guardian/Foster Parent
☐ Parent ☐ Legal Custodian

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Signature Date

To those receiving information under this authorization: **This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.**

Revised 7/2016