domestic abuse project
DAP

AUTHORIZATION AND CONSENT TO CONTACT PARTNER AND/OR FORMER PARTNER

Participant Information

Last Name:	**First Name:**	**Date of Birth:**

Name of Partner Involved in Incident of Abuse:

Please choose one: Current Partner Former Partner

Will your partner involved in the incident of abuse be attending DAP? Yes No

Partner's / Former Partner's Name:	**Home Phone:**	**Other Phone:**

Street Address:	**City, State, Zip:**

Name of Current Partner if different from above:

Do you have a current partner? Yes No

Will your current partner be attending DAP? Yes No N/A

Current Partner's Name:	**Home Phone:**	**Other Phone:**

Street Address:	**City, State, Zip:**

Purpose of Partner Contact:

It is the policy of the Domestic Abuse Project to require that you give DAP written permission to contact your partner, ex-partner, etc. We require this for the following reasons:

- We attempt to call your partner to introduce ourselves and our programs (Victim Survivor Program, Child and Adolescent Program) and extend an invitation to your partner to sign up for these services.
- We call your partner to briefly explain the Intervention and Prevention Program and encourage your partner to call if they have any questions and concerns.
- We might call your partner if you leave the group angry or escalated and we have reason to fear for your partner's safety.
- We call your partner about six months after you complete group to ask questions about any behavior changes since group. This information is used strictly to evaluate the effectiveness of DAP's services.
- DAP has a strict policy regarding confidentiality, and we do not discuss with your partner the content of your work in group or details of what you discuss. We share information with your partner only if we have concerns about your progress in the program or worries about your partner's safety.

Contact Authorization:

I understand that this authorization will remain in effect for one year unless canceled by me in writing. I understand that my written cancellation will become effective when the provider receives that written notice from me. A photocopy of this authorization will be treated in the same manner as the original.

Participant Signature:	**Date:**