domestic abuse project
DAP

AUTHORIZATION AND CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Participant Information

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

Information to be Released to or Exchanged With

Name:		**Organization or Affiliation:**
Street address:		**City, State, Zip:**
Phone:	**Fax:**	**Email:**

Type of Information to be Released

The purpose of exchanging information is to improve service delivery, enhance treatment planning and enhance the safety of all involved.

Yes	No	Care Coordination (including attendance, participation, services received, service recommendations, and progress in programming)
Yes	No	Group topics / Participation in group
Yes	No	Summary of participant records / Completion letter
Yes	No	Psychological testing results
Yes	No	School/Education files
Yes	No	Police reports and/or Pre-Sentencing Investigation (PSI)
Yes	No	Copies of any court documents pertinent for advocacy in criminal and/or civil court
Yes	No	Other (specify):

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Type of information to be Obtained

The purpose of obtaining information is to improve service delivery, enhance treatment planning and enhance the safety of all involved. Information will be shared via phone contact and/or letters via mail or fax.

Yes	No	Care Coordination (including attendance, participation, services received, service recommendations, and progress in programming)
Yes	No	Group topics / Participation in group
Yes	No	Summary of participant records / Completion letter
Yes	No	Psychological testing results
Yes	No	School/Education files
Yes	No	Police reports and/or Pre-Sentencing Investigation (PSI)
Yes	No	Copies of any court documents pertinent for advocacy in criminal and/or civil court
Yes	No	Other (specify):

Purpose for Release

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

I understand that if applicable, if my probation officer and/or new CPS worker changes within the same county, this release covers the exchange of information with the new probation officer and/or new CPS worker.

I hereby authorize the identified individual or agency to release, obtain, or exchange the requested information within the time frame above, unless revoked in writing.

Signatures

Participant:	**Date:**
DAP Representative:	**Date:**