

**F.I.R.S.T.**  
**Consent for Interagency Release of Information**

Regarding \_\_\_\_\_ DOB \_\_\_\_\_

I \_\_\_\_\_-authorize the agencies below to disclose the following information to F.I.R.S.T. : (Please check the appropriate blanks).

\_\_\_\_ DSS \_\_\_\_\_ County                      \_\_\_\_\_ Therapist \_\_\_\_\_

\_\_\_\_ Family Representative                      \_\_\_\_\_ Physician \_\_\_\_\_

\_\_\_\_ Juvenile Justice/County Services                      \_\_\_\_\_ Inpatient Psychiatric Treatment

\_\_\_\_ Mental Health Agencies                      \_\_\_\_\_ School System \_\_\_\_\_

\_\_\_\_ Guardian Ad Litem                      \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_ Service Coordinator/Case Manager                      \_\_\_\_\_ Other \_\_\_\_\_

To disclose to each other the following identifying information from my records:

\_\_\_\_ Speech/Language Evaluations

\_\_\_\_ Occupational Therapy/Physical Therapy Evaluations

\_\_\_\_ Individualized Family Service Plans

\_\_\_\_ Results of Psychological/ Psychiatric Medical Evaluations

\_\_\_\_ Recommendations for Treatment Planning

\_\_\_\_ Health/Medical Records

\_\_\_\_ Diagnostic and Treatment Progress

\_\_\_\_ Court Journal Entry

\_\_\_\_ Individualized Education Plans

\_\_\_\_ Other: (specify) \_\_\_\_\_

I am aware that this information will be strictly confidential and will be used in my best interest to identify, plan and provide services. I certify that this authorization is made freely without coercion. I understand that the information to be released is protected under state and federal laws, and cannot be redisclosed without my further consent unless provided by state and federal laws. I understand this consent of disclosure maybe revoked by me at any time, except to the extent of action has been taken in reliance thereon and furthermore I the undersigned am aware o my legal rights and acknowledge upon signing this consent, I am waiving my rights on confidentiality. This consent will expire 365 days from date signed. (not to exceed 365 days)

Name printed \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Other (specify relationship) \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_