



Consent Form

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Asheville, NC 28802
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first@firstwnc.org

Regarding _____ DOB _____

I _____-authorize the agencies below to disclose the following information to F.I.R.S.T.:

- | | |
|---------------------------------------|--|
| _____ School System _____ | _____ Service Coordinator/Case Manager |
| _____ Referring Agency _____ | _____ Physician _____ |
| _____ Inpatient Psychiatric Treatment | _____ Mental Health Agencies |
| _____ Other _____ | _____ Other _____ |

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

- _____ (IFSP) Individualized Family Service Plans and/or Evaluations
- _____ (IEP) Individualized Education Plans and/or Evaluations
- _____ Medical Evaluations, Reports and Treatments
- _____ 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 re disclosed 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 _____