GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Authorization to Refer and Disclose Information to Healthy Families/Thriving Communities Collaboratives

Si usted no entiende el idioma Inglés, favor de pedir esta forma en Español.

Instructions

- The "Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative" (Authorization) is used by Child and Family Services Agency (CFSA) staff to authorize the referral of a client to a Healthy Families Thriving Community Collaborative (Collaborative) for services. It also permits CFSA to provide non-health related information about the client to the Collaborative.

- The Authorization may be signed by an individual who is referred for individual services (for example, a former foster child who aged out of foster care) or by a parent or guardian on behalf of herself/himself and the minor children. If there are questions about who can sign, contact the Office of General Counsel.

- If medical or dental information also needs to be sent to the Collaborative, use the "Authorization to Disclose Medical or Dental Information" to permit that disclosure. Similarly, if mental health or substance abuse information also needs to be sent to the Collaborative, use the "Authorization to Disclose Mental Health and Substance Abuse Information".

- If the client is Spanish-speaking and does not read English, give her or him the Spanish version of this Authorization.

- If a client is physically unable to complete the Authorization, CFSA staff may complete the Authorization under the direction of the client, as long as the client signs or marks the Authorization.

- The Authorization must be witnessed by the CFSA social worker.

- When the case is sent to the Collaborative, the signed and witnessed Authorization should be sent along with the completed "Case Referral Form to the Collaborative".

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See Attached Instructions

I. Referral to Collaborative

1. I, _____, hereby authorize the Child and Family Services Agency (CFSA) to refer
Name of Individual, Parent or Guardian
the individuals named below to the _____ Collaborative (Collaborative).
Name of Collaborative

2. The purpose of the referral is: _____
_____
_____
_____.

II. Individual(s) being Referred *If additional individuals are being referred, please identify them on Attachment A. This includes identifying the spouse/significant other and all children in the family who are being referred.*

1. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

III. Information to be Released *Use additional pages if necessary.*

1. To enable the Collaborative to serve me/us, I further authorize CFSA to disclose information to the Collaborative as follows: _____
_____
_____
_____
_____.

IV. Signature

- I understand that this Authorization to Refer and Disclose Information to Healthy Families Thriving Community Collaborative (Authorization) permits the release of both oral information and documents.
- I understand that the information used or disclosed on the basis of this Authorization may not be disclosed again by the recipient except by my express authorization or otherwise in accordance with applicable law.
- I understand that I may revoke this Authorization at any time by giving my written revocation to:

D.C. Child and Family Services Agency

attn: _____, Social Worker
400 6th Street S.W.
Washington, DC 20024

- I understand that revocation of this Authorization will *not* affect any action CFSA took in reliance of this Authorization before it received written notice of my revocation.
- I understand that this Authorization will expire six (6) months from the date on which I sign it, and that I may sign a new Authorization for an additional six (6) month period.
- I have received a copy of this Authorization.

_____ _____
Individual's Signature *Date*

_____
Name printed

Address: _____

Telephone Number: _____

Relationship to persons named in Part II: ► Parent ► Legal guardian ► Self (if over 18 years of age) *Note: if not the parent, legal guardian or self (and over 18 years of age), discuss with Office of the General Counsel*

Witness: _____
Social Worker's Signature

_____
Social Worker's Name Printed

Attachment A: Individual(s) being Referred Continuation Sheet
Authorization to Refer and Disclose Information to Health Families Thriving Community Collaborative

II. Individual(s) being Referred *If additional individuals are being referred, please identify them on Attachment A. Use as many sheets as needed.*

2. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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3. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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4. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____

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5. Name:_____
Last First Middle

D.O.B. _____ Social Security No. _____--_____--_____

Race: _____ Gender: Male Female (Circle One)

Current Address: _____ _____
No. & Street City State Dates of Residency

Telephone Number: _____