Recovery and Academic Program Consent for Services and Authorization for Release of Confidential Information

Office of Student and Family Support and Engagement
MONTGOMERY COUNTY PUBLIC SCHOOLS (MCPS)
Carver Educational Services Center (CESC)
850 Hungerford Drive, Room 50, Rockville, Maryland 20850

MCPS CLEAR FORM

PART OF THE SHEPPARD PRATT HEALTH SYSTEM

Sheppard Pratt HEALTH SYSTEM | WAY STATION | Mosaic | Family Services, Inc.

MCPS Form 335-75A
August 2018

CLIENT INFORMATION

Client Full Legal Name: _____ Date of Birth ____/____/_____
Address (Street, City, State, ZIP):_____
E-mail:_____Telephone _____-_____-_____

CONSENT FOR SERVICES

I consent to the provision of Recovery and Academic Program (RAP) services, effective *(Date of Enrollment)* ____/____/_____

❑ I consent to the taking and use of photographs, videos, and audio recordings for educational purposes related to RAP only.
❑ I consent to the use of social media by the Landing to contact the RAP student.
❑ I consent to the use of the Landing's after-school transportation.
❑ I consent to the use of the Landing's equipment onsite.

RELEASE OF INFORMATION

I authorize The Landing *(a program of Family Services, Inc.)* and _____

Montgomery County Public School located at _____ , Telephone _____-_____-_____

to disclose to each other the following specific information. This information may be shared verbally, electronically and/or in written form. The purpose of disclosure is to provide: ❑ Provision of Service ❑ Continuum of Care ❑ Educational Programming for the following dates of service: from____/____/_____to ____/____/_____.

From Landing to School:
❑ Admission Assessment/Intake
❑ RAP Attendance Records
❑ Individual Recovery Plan Progress Report
❑ Updates to Emergency Information
❑ Recovery Information Progress
❑ Relapse Information
❑ Assessment of Recovery Progress

From School to Landing (print reports from *MyMCPS*):
❑ Enrollment Information/Emergency Contact
❑ School Report Card(s)
❑ Transcript
❑ Attendance Report Summary
❑ Discipline Report Summary
❑ Naviance® Career Readiness Planning (counselor)

❑ Other _____

This authorization will expire after termination/completion of services, one year from the date signed, or on____/____/_____, whichever comes first. Please initial next to each section to indicate that you have read and understand what this authorization form entails.

____ Participation in the RAP program is voluntary; however, receipt of RAP services requires disclosure of the information referenced above regarding the individual receiving services to coordinate and provide comprehensive services. If I opt out of this authorization I may not be eligible to received RAP services, but may be able to receive direct services though The Landing program.

____ I understand that I have the right to refuse to sign this Authorization for Release of Information. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure services. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

____ I understand that de-identified personal information may be shared between MCPS and the Landing to evaluate RAP effectiveness. No personally identifiable information of RAP students or parents/guardians will be included and information will be destroyed when no longer needed for evaluation purposes.

____ I, the undersigned, have read and understand the Landing's liability policy related to the after-school transportation provided and use of equipment onsite.

____ I, the undersigned, have read the above and authorize Family Services, Inc. and person/organization named above to disclose information as described above. I understand that this authorization may be withdrawn in writing as any time except to the extent that the action has been taken in reliance upon it or as described in the Sheppard Pratt Notice of Privacy Practices. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV Testing, HIV results, or AIDS information.

____ I understand that disclosure of health information to a party other than one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the health information is protected under federal confidentiality rule 42 CFR Part 2. This facility is released and discharged of any liability and the undersigned will hold Family Services, Inc. harmless for complying with this "Authorization for Release of Information."

Date: ____/____/_____ Signature of Client: _____

Date: ____/____/_____ Signature of Client Parent/Guardian, Authorized Rep.: _____

Date: ____/____/_____ Signature of Witness: _____