SAMPLE

INTERAGENCY CONSENT TO RELEASE INFORMATION

Sharing information helps agencies provide better services to me/my child and/or my family. Only those agencies listed below that are planning or giving services to me or my child may receive information.

When relevant, shared information will include:

* my/child's full name
* social security number
* telephone number
* birthdate
* address
* names of parents/brothers/sisters/spouse
* items specified below

I understand that this form is **not** used to release information about drug and alcohol treatment.

I, _____, also allow all of the listed agencies to share the following information about my child/me, _____ (birthdate _____).

Please specify: INFORMATION THAT MAY BE SHARED

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please specify: AGENCIES THAT MAY SEND/RECEIVE INFORMATION
(Include Originating Agency Name)

_____

_____

_____

_____

_____

_____

_____

_____

_____

AGREEMENT TO RELEASE

This permission is good for one year after I sign it.

I agree to the interagency sharing of information. I can take away my permission at any time. I can also change it at any time unless the information has already been released.

Print Name: _____

Signature: _____

Date: _____

Please check all that apply:

Parent [ ] Guardian [ ] Legal Adult (18 years) [ ] Minor 12-18, required below *[ ] Custodian [ ]

*A minor must specifically consent to the release of HIV [ ], STD [ ], and pregnancy information [ ].
Signature of minor: _____ Date _____

ORGANIZATION'S AFFIRMATION

As the participating organization's representative, I affirm that I have reviewed this form and its use with the consenting person and that to the best of my knowledge he/she understands.

Witness _____ Date _____

Agency _____

TRANSLATOR'S STATEMENT

I have orally translated/read/signed the above into _____ (language). To the best of my knowledge, I believe the consenting person understands the nature and use of this form.

Translator's Signature _____ Date _____

……..

Revocation Statement

I, _____ (consenting person), take away the consent I gave to _____ (originating organization) on _____ (date). I understand that _____ (originating organization) will notify any participating organization to which information has been sent or from which information has been received.

Signature _____ Date _____

Witness _____ Date _____

Agency _____ Revocation letter attached (Yes/No) _____

♦ The Interagency Consent to Release Information Form is based on the Interagency Confidentiality Agreement for Accessibility in Data Sharing between Participating Organizations: Department of Health & Social Services (DHSS), Department of Services for Children, Youth and their Families (DSCYF), Department of Education (DOE), Department of Correction (DOC), Department of Labor (DOL) and local school districts. This document has been approved by the Attorney General's Office. This form may not be altered in any manner without written authorization from the State of Delaware Interagency Confidentiality Committee. This form may be photocopied for use by the participating organizations.

The State of Delaware does not discriminate or deny services on the basis of race, religion, color, national origin, sex, disability and/or age.