Ensuring that child sex trafficking victims receive quality care and services in the State of Georgia

Consent Form and Obtain/ Release of Information

Today's Date: _____

Name: _____

Date of Birth: _____

Section A: Consent to Services

By signing this form, I consent to receive services and work with Georgia Cares.

Section B: Use and Disclosure of Information

By signing this form, I authorize the disclosure of my individually identifiable information. Information that may be used or disclosed based on this authorization is as follows:

I authorize the release of my complete records including:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
- Information concerning the testing for HIV (Human Immune Virus) and /or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
- Privileged communications between a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning communications with them.
- All education information; including education records created or received by the school system. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluations

I authorize the disclosure of my complete records and identifiable information **by the following and to the following parties:** Department of Juvenile Justice, Department of Family and Children Services, Educational Provider, Juvenile Court, District Attorney's Office, Law Enforcement, Mental Health Providers, Medical Providers, and any other providers as deemed necessary.

I authorize for Georgia Cares to take a photograph of the abovementioned youth, to be shared **by the following and to the following parties**: Department of Juvenile Justice, Department of Family and Children Services, Educational Provider, Juvenile Court, District Attorney's Office, Law Enforcement, Mental Health Providers, Medical Providers, National Center for Missing and Exploited Children (NCMEC) and any other providers as deemed necessary.

□I authorize the release of the complete records **except** for the following information or to the following party:

_____.

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is for Care Coordination, to possibly seek victim's compensation, possible completion of a NCMEC application and other needed uses.

Section D: Expiration

Consent for Release of Information expires **24 months** from the date it was signed. Consent for Information must last no longer than reasonably necessary to serve the purpose for which consent is given. 42 CFR 2.31 (a) (9)

□ By checking this box, I authorize the following expiration event or date that when it occurs, will prohibit Georgia Cares from giving or receiving information as described above (detail expiration date): _____.

Section E: Other Important Information

1. I understand that Georgia Cares cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that I may refuse to sign this Authorization and that my refusal to sign may affect my ability to obtain services through Georgia Cares.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by Georgia Cares in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.

Date: _____ Signature of Youth: _____

Date: _____ Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____ Signature of Witness (Title): _____