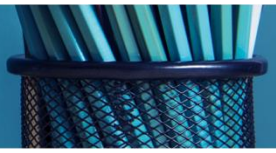
SCHOOL-BASED LIAISONS



Dear Parent or Guardian,

I am writing to request your permission to serve your child through the school-based clinician program for this academic school year. We are contracted by the School System and your child's school specifically to offer free educational and behavioral health services during the school day via phone, telehealth, or face-to-face.

Our objective is to identify and address academic, emotional, behavioral, and social areas of opportunity for any student. Your participation in this process is welcomed and invaluable to the ongoing success of your student. Services offered through this program are provided by a Master's level mental health professional from *Pathways of West Tennessee Healthcare* and may include but are not limited to assessments, classroom observation, and individual, group, and classroom counseling and activities.

For your student to receive any ongoing, individualized services from this program either face-to-face or through telehealth, we need your parental consent and permission. In addition, for us to communicate to the school any recommendations or updates that may benefit your student, we need your consent and permission to release that information from us to the school and vice versa. Individualized services can begin once both of these consents are agreed to in writing, and you have the full and expressed right to withdraw this consent at any time.

Included in this packet are the consent and permission form as well as the release form allowing the school and me to communicate with one another. You'll be asked to include your student's name and your contact info in addition to your signatures.

We are excited to be offering this service to every student in the school all year at no cost to you or your student, and it will be my privilege to serve your family and this school. If you have any questions or need any additional information, or if you would like to request a conference via any means whether phone, telehealth, or in person, please do not hesitate to reach out to me now or in the days to come.

Best Regards,

Christie Polk, LCSW
School-Based Behavioral Health Liaison
Email | christie.polk@wth.org
Phone | 731 501 1366
Zoom ID | 636 108 9788

TN Department of Mental Health & Substance Abuse Services

The School-Based Behavioral Health Liaison Program offered by Pathways in partnership with your school is funded through a grant from the Tennessee Department of Mental Health & Substance Abuse Services (TDMHSAS).

FAMILY+ SCHOOL PARTNERSHIPS
West Tennessee HEALTHCARE | Pathways

SCHOOL YEAR 2021-2022 **SCHOOL-BASED PROVIDER & CREDENTIALS** Christie Polk, LCSW

INFORMED CONSENT AND PERMISSION FOR SERVICES

I understand that I am consenting and agreeing only to those services that the school-based provider listed above is qualified to provide within the scope of the provider's license, credentials, certification or training, and the scope of license, credentials, certification, or training of the behavioral care providers directly supervising the services received by my student.

I understand that my student's school has partnered with the provider listed above to identify and address academic, emotional, behavioral, and social areas of opportunity for any student. Services offered through this program are provided by a Master's level mental health professional from Pathways of West Tennessee Healthcare and may include but are not limited to assessments, individual, group, and classroom counseling and activities. I understand that I am giving permission for the school-based provider to offer these services, and that the provider will protect the confidentiality and privacy of my student and my family as is allowed by law. I am able to revoke this consent and permission at any time by submitting this request in writing.

I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent for treatment on behalf of this individual.

I understand that treatment may involve the risk of remembering painful events and can arouse intense emotions of fear or anger. Other feelings of anxiety, depression, frustration, loneliness or helplessness may also be aroused. I understand that my student's condition may worsen as a result of the process of counseling and drastic lifestyle changes might occur that could negatively affect my student's relationships and/or ability to cope. I understand the benefits of treatment may be that my student will be better able to handle or cope with his or her family, work or school, and social relationships or that my student may have a better understanding of himself or herself and the personalized goals and values which could lead to growth as a person. I realize, however, there is no guarantee of positive results.

I understand the information listed above, am aware of the risks and limitations of behavioral health services. As the legal parent/guardian of (enter your student's name) _____, understanding the information above and being aware of the risks and limitations of behavioral health services, I give my permission and consent by signing below for my child to receive school-based services during the current academic school year.

_____ **DATE** _____

PLEASE PRINT THEN SIGN

PERMISSION FOR TELEHEALTH SERVICE DELIVERY

I understand that I am consenting and agreeing for these services to be offered via telephone, face-to-face, and secure telehealth. I understand that my student's privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted is similar to the potential interception of a phone call, and that there is currently no known risk of services being offered via telehealth.

If my student chooses to receive services via telehealth, he or she will be given an explanation of any device or software used for telehealth and will have the opportunity to ask questions prior to use. My student will be notified as to who is in the room at the remote site, and we may refuse to participate or decide to stop participation at any time. I understand that our refusal to participate or decide to stop participation will be documented in my student's medical record.

If I choose to include additional contact information below including phone, email, etc., I am giving permission to be contacted by these means.

I understand the information listed above, and give permission and consent by signing below for my child to receive these school-based services via telephone and telehealth for the current academic school year. I also give my permission to be contacted by any of the means I have included below.

PHONE 1 _____ **PHONE 2** _____

EMAIL _____

_____ **DATE** _____

PLEASE PRINT THEN SIGN

CLIENT (CL) NAME:	CL DATE OF BIRTH:	CL SS NUMBER OR LAST 4 DIGITS:
	CL EMAIL ADDRESS:	

INFORMATION BEING RELEASED BY AND TO PATHWAYS BEHAVIORAL HEALTH, OF WEST TENNESSEE HEALTHCARE

RELEASE OF RECORDS	ADDRESS:	CITY:	
[✔] TO Crockett County School System; Middle, High, & Alternative Schools [✔] FROM	102 North Cavalier Drive	Alamo	
	PHONE NUMBER: (731) 696-2604	STATE: TN	ZIP: 38001

***If releasing to an individual, is there a treating provider relationship with the individual?** ____ Yes ____ No
If you answered "yes," this treating provider relationship is a ___ Past ___ Current ___ Future **relationship.**

TREATMENT DATES: Academic Year 2020-2021

TREATMENT LOCATION(S): ____ Inpatient ____ Outpatient ✔ Other
(Specify if Other): School, Telehealth, Phone

DISCLOSURE PURPOSE(S):
- ✔ Continuing Care
- ✔ School
- ____ Other (*specify*)
- ____ Insurance
- ____ Patient Portal Access
- ✔ Family Involvement
- ____ Request of Individual

DISCLOSURE METHOD(S):
- ✔ Paper
- ✔ CD, DVD, External Drive, etc.
- ____ Other Method *(specify)* _____
- ✔ Fax
- ✔ Email
- ✔ Verbal Communication
- ✔ SMS/APP

If sending *unsecured/unencrypted* communication via email, SMS/APP, or other means over the internet there is some level of risk that the information could be read or otherwise accessed by a third party while in transit. Your mark by **any of these items** communicate that you understand and wish for your information to be sent unencrypted by the agency when and if necessary or beneficial to you.

INFORMATION AND DOCUMENT(S) APPROVED TO DISCLOSE:

- ____ Psychosocial Assessment
- ____ Treatment Plan
- ____ Discharge Summary
- ____ Medical Progress Notes / Orders
- ____ Clinical Progress Notes
- ____ Labs (may include AIDS/HIV)
- ____ Medical History
- ____ Nursing Notes
- ✔ Letter
- ____ Entire Legal Chart
- ✔ Other Assessments
- ✔ Verbal Communication
- ____ Completion of Submitted Form
- ____ Admission History Crisis/IPU/Detox/CSU
- ____ Other (specify): _____

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above-indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be re-disclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of substance use disorder is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. The authorization will expire in 12 months unless I provide an alternate expiration date or event:_____
   Patient Portal access will expire upon termination of Portal account.

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

_____
Signature of Patient

_____
Date

Med Red # NA _____

_____
Signature of Patient's Authorized Representative

___Mother ___Father ___Legal Guardian ____other

if other, please specify_____

Witness_____

West Tennessee HEALTHCARE™ | Pathways

CORPORATE FAX | 731-541-8327
MEDICAL RECORDS FAX | 731-541-8265

CORPORATE	DYER CO	EAP	GIBSON CO	HAYWOOD CO	HENDERSON CO	OBION CO
238 Summar Dr Jackson, TN 38301 P 731.541.8267 F 731.541.8327 Monday – Friday 8AM – 5PM	1720 Woodlawn Ave Dyersburg, TN 38024 P 731.285.1393 F 731.286.1423 Monday – Friday 8AM – 5PM	33 Director's Row, Ste A Jackson, TN 38305 P 731.541.7605 F 731.661.6277 Monday – Friday 8AM – 5PM	4039 S Highland St Milan, TN 38353 P 731.723.1327 F 731.723.1339 Monday – Friday 8AM – 5PM	1120 Tammbell St Brownsville, TN 38012 P 731.772.4685 F 731.772.3072 Monday – Friday 8AM – 5PM	HWY 412 West, Ste B Lexington, TN 38351 P 731.968.8197 F 731.967.1749 Monday – Friday 8AM – 5PM	930 Mount Zion Rd Union City, TN 38261 P 731.885.9333 F 731.885.5860 Monday – Friday 8AM – 5PM