KidsNet Behavioral Health Screening Referral Consent for Services

KSL, School Counselor and Social Work Use Only

Referring school:	Home School (GIVE Only):	Grade:
School Counselor, Social Worker, Admin. Name:	Phone:	
Date of last RTI:	Date of last SST:	
Student IEP: Y or N		
Student Identification #:		
KSL Only- Date Received by KSL:	Referral code:	

Referral Information

Date: ______________________ Student name: ____

Parent(s)/Guardian(s) name:____________________________________Language Spoken at home: __________________
Address:____ City/Zip:___________________________________
Phone (Circle Preferred number): (home)___________________(cell)_____________________(work)________________
Reason for referral (describe behavior or situation causing concern): ____

____

Parents Email:____
Is the child/youth currently receiving counseling or therapy services? Yes / No If Yes, please provide the service

providers contact information: ____

Behavioral Health Insurance Provider:

- o Medicaid (select one type below)
  - o APS Healthcare
  - o Peachstate (Cenpatico)
  - o Wellcare (Magellan)
  - o Amerigroup
- o Peachcare
- o Uninsured/Family will self pay for services
- o Private Insurance *(specify)*:______________________________

Parental Consent to Release Referral Information to KIDSNET School Liaison (KSL):
I authorize Gwinnett County Public Schools to release and obtain information regarding my child____________________,
DOB___ /___ /___ , who attends________________________________School and is in the_______grade to KidsNet.

I understand that a representative from KidsNet (KidsNet School Liaison) will be given my contact information and that I will be contacted by a KidsNet School Liaison to obtain a signed information specific release and to arrange a private and confidential behavioral health screening of my child.
The purpose of the screening is to help determine what behavioral health needs your youth may have, and then to link your family to resources within the community that may help in meeting your needs.

I give permission for my youth to be screened for behavioral health needs by the, KidsNet School Liaison.

The KidsNet School Liaison operates collaboratively, but independently from Gwinnett County Public Schools and maintains records associated with student screenings separate, in part and in whole, from student records. Results obtained from KidsNet School Liaison screenings will be kept confidential except for those with a need to know.

_________________________________ _________________________________ _______________
Printed name of parent/guardian Signature of parent/guardian Date

Division of FAMILY & CHILDREN SERVICES GEORGIA DEPARTMENT OF HUMAN RESOURCES DHR

Unified Release of Information

Name: ________________________________ Date of Birth: ____________ Date: ____________

Section A1and A2: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my child's health/education information **by and to** the following:

- ☐ KidsNet Evaluation
- ☐ Chestnut Health Systems
- ☐ Department of Behavioral Health and Developmental Disabilities
- ☐ Public Schools
- ☐ Mental Health Center
- ☐ Juvenile Court
- ☐ Department of Juvenile Justice
- ☐ Department of Family and Children Services
- ☐ Other ______________________________

Section B: Scope & Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (check one):

- ☐ All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
  - 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 me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- ☐ All health information about me as described in the preceding checkbox, excluding the following:______________________________
- ☐ Specific health information **including only** the following:______________________________
- ☐ All education information about me; including education records created or received by any school system. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is (check one):

- ☐ Specifically, the following_____KIDSNET EVALUATION______________________________
- ☐ The youth chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D: Expiration

NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure

Event______________________________Consent for Release of Health Information expires 15 months from the date it was signed. Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

Section E: Other Important Information

1. I understand that View Point Health 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, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.
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 View Point Health 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	Signature of Parent/Legal Guardian
Date	Signature of Witness (Title):