



Universal Referral/Release

Authorization for Request/Release of Client Information

Fax completed form to
Family Resource Center
Fax 209 381-5979
For questions, Please call
Magdalena Mugica
209 381-5983

Referral for: Name (Last, First, MI)			SSN: (last 4 digits)	
DOB:	Age:	Sex:	Phone #:	Message #:
Address: (Street, City, State, Zip)				
Is an interpreter needed: ____ No ____ Yes <i>If Yes, Language:</i>				
Referring Agency:		Referred by: (Name)		Phone #/Extension:

I understand that my information is legally privileged and protected under State and Federal Confidentiality Regulations (in accordance with Federal Regulation 42 CFR and 45 CFR Parts 160 and 164; Education Code Section 49069; California Welfare and Institutions Code Sections 4514, 5328, and 10850) and cannot be disclosed without my written consent, and is intended only for the use of the named individual(s) or entity unless otherwise provided for in the regulations. Redisclosure without specific written consent of the person to whom the information pertains is strictly prohibited. I understand I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. This information is necessary in coordinating assessments, services, and case management for the above-named. All children 12 years of age and older must give consent to release Drug/Alcohol records. A general authorization (Universal Release/Exchange of Information Form) for the release of all medical or mental health records is not sufficient for this purpose. If the reader of this message is not the intended recipient, you are advised not to read the attachments and you are hereby notified that any dissemination, distribution, or copy is strictly prohibited.

Service discussed within the scope of this authorization is confidential, with these exceptions: (1) Mandated reporters are compelled by law to inform the appropriate person(s) should they hear and believe that you or a family member are in danger of hurting yourself or someone else; (2) Should there be reasonable suspicion that a child, dependent adult, and/or an elderly adult has been abused; and (3) Under the Tarasoff Statute should you make a threat to harm an identified victim, both the victim and law enforcement will be notified of this threat.

SERVICES REQUESTED

For the purpose of providing, verifying, and coordinating services, place a check in the box in front of the agencies that provide/may provide services through the System of Care.

- | | |
|---|---|
| ☐ Adult Services | ☐ Housing Authority |
| ☐ Anger Management: _____ | ☐ Human Services Agency (ESB/FSB) |
| ☐ Cal-Learn Date/Time: _____ | ☐ Increased Level of Care (13/14 only) |
| ☐ California's Children Services | ☐ Individual School District: _____ |
| ☐ Central Valley Occupational Center | ☐ Mental Health |
| ☐ Central Valley Regional Center | ☐ Merced College |
| ☐ Child Abuse Treatment (CHAT) | ☐ Merced County Office of Education |
| ☐ Child Welfare Services | ☐ Probation |
| ☐ Children's Placement Council | ☐ Public Health |
| ☐ CWS - Independent Living | ☐ Public Health - Parenting |

System of Care
Universal Referral/Release

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- | | |
|--|---|
| ☐ Department of Rehabilitation
☐ Worknet
☐ District Attorney/Victim Witness
☐ Drug and Alcohol - The Center
☐ Primary Care Physician: _____
☐ Family Service Center
☐ Head Start
☐ Home Visitors
☐ H.O.P.E.S. | ☐ Public Health - Young Parents Program
☐ ReDirect Program
☐ Student Study Team
☐ Supportive On-going Services (SOS)
☐ Valley Crisis Center
☐ Westside Family Service Center
☐ Other: _____
☐ Other: _____ |
|--|---|

I hereby authorize the agencies checked about to exchange the following information:

- | | |
|---|---|
| ☐ Assessments
☐ Educational Assessment, Behavioral Reports -
(Include school observation/educational tests)
☐ Pertinent Disposition of Legal Status
☐ Progress in Court-Ordered/Voluntary Treatment
Plan | ☐ Records Requested
☐ Status of Medi-Cal Eligibility
☐ Time and Attendance
☐ Toxicology Screens
☐ Other: _____ |
|---|---|

I have read the foregoing, understand its content, and agree to the conditions stipulated therein.

THIS CONSENT EXPIRES AUTOMATICALLY SIX (6) MONTHS AFTER THIS DATE

Client's Signature	Date	Print Parent/Guardian(s) Name	Parent/Guardian Signature	Date
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For Mental Health Clients Only

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event, this authorization expires automatically on _____.

To revoke this authorization, please address the notification to:

Merced County Department of Mental Health
Attn: Compliance Officer
P. O. Box 839
Merced, CA 95341

In your notice, please include your name, date of birth, and a description of the authorization to be revoked. Including a copy of the authorization you want revoked will greatly improve our ability to assist you in this matter.

Description of Problem

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Staff Signature: _____ Date: _____

Client has a right to this form/Client has received a copy of this form on: