UMCHS, Inc.

110 NE 4th ST • Hermiston, OR 97850 • 541-564-6878 or Toll Free 1-800-559-5878

Referral to Mental Health Consultant
and
Authorization to Release Information to Mental Health Consultant

Child's Name ____ Date of Birth __________________

Name of Parent or Legal Guardian ___________________________________Phone#_________________

Name of Individual or Agency authorized to release records: **UMCHS, Inc.**

Name of Individual or Agency authorized to receive records **Annette Chastain and Associates**

380 NW Montgomery Avenue Redmond, OR 97756 541-786-5554/1-866-910-2366
Address/City/State/Zip Phone/Fax Number

Name of Teacher(s)_____________________________________Classroom________________________

☐ **Allow information to be shared both ways**

Please initial specific information to be disclosed and released:

___Screening/Assessment Results ___Child Evaluations/IFSP Records ___Family Anecdotal Records

___Child Progress Reports ___Child Behavioral Observations and Assessments

___Other (specify):____

Reason for disclosure and use of information:____

☐ **Phone Call** ☐ **Individual Child Observation** ☐ **Consult**

Prohibition on re-disclosure: This information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42CFR) Part 2 prohibits the recipient of this information from making any further disclosure of this information except with the specific written consent of the person to whom it pertains or the legal guardian of the minor child to whom the information pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

Revocation: I understand that I may revoke this authorization at any time by notifying Head Start in writing. I understand that if I revoke this authorization, it will not affect any actions Eastern Oregon Head Start took while the authorization was in place.

Expiration date: This authorization will expire one year from the date signed unless otherwise revoked.

Consent for Disclosure: I recognize that the information disclosed may contain information that is protected by Federal and State law, and I specifically consent to disclosure of such information. Eastern Oregon Head Start will not make authorization a condition for participation in the Head Start Program.

Signature of Parent or Legal Guardian: ____________________________________ Date:________________