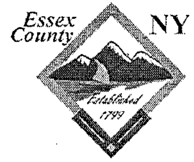
ESSEX COUNTY CHILD SERVING SYSTEM
INTER-AGENCY RELEASE/EXCHANGE OF INFORMATION



MISSION: TO ENSURE THAT ALL ESSEX COUNTY CHILDREN REFERRED FOR SERVICES WILL HAVE ACCESS TO SERVICES APPROPRIATE TO THEIR NEEDS THROUGH A COLLABORATIVE, STRENGTH-BASED, SEAMLESS SYSTEM.

The following is a list of Essex County government and not-for-profit agencies working together to provide a comprehensive and collaborative array of services to the children and families of Essex County. To that end, representatives of those agencies and programs will be meeting regularly to update each other on their efforts on behalf of those children and families. In order to facilitate the exchange of relevant information, this release has been designed as a way of allowing for that sharing of information. Representatives from the following agencies and programs will be included in these discussions:
Essex County Department of Social Services, Essex County Probation, Essex County Mental Health Clinic, Essex County Department of Public Health, Mobile Mental Health Services, Essex County Youth Bureau, Essex County Attorney's Office, North Country Conflict Resolution Services, Inc., Cornell Cooperative Extension, Family Corner, Adirondack Community Action Program (ACAP), North Country Center for Independence, CPA of the North County, Families First, TEAM Substance Abuse Prevention Program, Essex County Youth Advocate Program (YAP), Essex County Community Services, NY State DDSO, Mountain Lake Services (ARC), St. Joseph's Outpatient Clinic, School: ________________________, other: ______________________ and parent representatives.

I, ______________________________ hereby consent to the release and exchange of relevant, necessary information regarding my son/daughter, ______________________, DOB, ______________ for the Child Serving System Meeting for one year. I understand that I will be notified by phone, in person, or in writing prior to any presentation or discussion at a specific meeting and can verbally revoke this authorization at that time. I also understand that this release will be presented at each meeting that my child will be discussed and that information will be shared by agencies and programs listed above for the purposes of insuring that service needs are identified and met without duplication. I further understand that medical records, mental health records and drug/alcohol treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 "HIPAA" and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
I further understand that, with prior notice provided, I am welcome to attend and participate in these inter-agency discussions whenever my child is scheduled for review.

____________________________	____________________________	__________
Parent/Guardian Signature	Relationship to Child	Date

____________________________	____________________________	__________
Witness	Title and Agency	Date

4/1/09