

AGENCY OF HUMAN SERVICES: CHILDRENS INTEGRATED SERVICES AUTHORIZATION

Name of Individual Served: _____ DOB: _____
(First) (Last)

Parent/Legal Representative: _____ Last 4 of SSN#: _____

The Children’s Integrated Services (CIS) Team of the Agency of Human Services (AHS) is a multidisciplinary team that provides early childhood expertise and support services for pregnant women and children 0 to 6 years old. Children’s Integrated Services involves a team of professionals that provide services in the following areas: Maternal and Child Nursing, Early Intervention, Early Childhood Mental Health, and Family Support. When a parent or young child is referred to CIS, the CIS Intake Coordinator will discuss the referral with the team. The Intake Coordinator may recommend that further assessment be conducted and/or that an appropriate specialist review information about the child and family.

I give my permission for the Children’s Integrated Services Intake Coordinator and/or other CIS Team members to share my referral, intake and any other information collected from me during the interview: (check all that apply)

- To determine the services that are necessary for my child and family
- To coordinate services across all Early Childhood providers
- To consult with professionals associated with the Early Childhood Consultation Team in my region when needed
- To share information with the following person(s) that I choose _____
- Other _____

I permit the Children’s Integrated Services Intake Coordinator and/or CIS Team members to obtain additional information from the following person(s) or entity(ies) (Person/Agency, Address, Phone, and Information Type)

- Primary Healthcare Provider: _____
- VDH-Children with Special Health Needs: _____
- Child Development Clinic: _____
- Child Care Provider: _____
- Mental Health Provider: _____
- Substance Abuse Counselor: _____
- Food/Nutrition Services: _____
- Housing Assistance Provider: _____
- Employment Assistance Provider: _____
- Economic Assistance Provider: _____
- Other: _____

By signing this form, I understand:

- The reason(s) I am being asked to release information.
- I do not have to agree to the release of information. However, by not giving authorization, my child and family will not be able to participate in the entire Children’s Integrated Services multidisciplinary review or assessment process.
- If I choose not to sign this form any benefits for which I or my child and family are entitled will not be affected.
- While the AHS takes every precaution to protect my health information once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- If I am authorizing AHS to share information about HIV-related or alcohol or drug treatment, the recipient may not share my information with others unless permitted to do so by law.
- I may revoke this authorization at any time except to the extent that it has been acted upon.
- If I do not revoke or update this authorization, it will be in effect as long as I am receiving services from AHS.
- I will be provided a copy of this form.
- All items on this form and my questions about this form have been answered.

Signature of Individual or Parent/Legal Representative	Relationship to Client	Date
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Name of Person Explaining Authorization Process	Organization / Position	Date
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