Wellness Networks In LAUSD

INFORMED CONSENT FOR PROVIDER CONTACT AND INITIAL REFERRAL

Student Information (please print):

10-digit LAUSD ID	Last Name	First Name	Date of Birth (DOB)	Advisory Period

AGREEMENT FOR CONSENT AND RELEASE TO SHARE INFORMATION

In support of my child's participation in the **Wellness Center located at Carson High School**, I understand and agree that the Wellness Network Providers working with my child may share information they have about my child with one another to coordinate services for my child. I understand that my child's and my participation in the Wellness Network is to access appropriate services to support my child's success. For purposes of this Agreement, I understand and agree that "information" shall be defined as any and all records, notes, or other documents or materials in the possession of the Wellness Network Provider that directly pertain to my child. I understand that State and Federal laws protect my privacy rights and the rights of my child; and information will not be shared without my express permission. By signing this Agreement, I understand I am giving permission to exchange the following information about my child only to the Providers, organizations and/or agencies **that I have indicated**: my child's name, address, phone number, grades, attendance, classes, disciplinary actions, interventions, and reason(s) for referral.

I understand that the Providers are not a part of the regular and ongoing program of the school of the Los Angeles Unified School District, and the services provided are not LAUSD or school sponsored activities or programs. The services are made available at the school/site for my convenience to obtain health/mental health services for my child. I understand that the Los Angeles Unified School District does not assume responsibility for the services provided by the Provider nor the fees that may be charged.

Wellness Network Partners/Organizations/Agencies (please check all agencies in which information can be shared):

- ☐ Los Angeles Unified School District, School Mental
- ☐ South Bay Family Health Care

Parent/Legal Guardian Information (please print):

Mother:				
Last Name	First Name	MI	DOB	Telephone #
Father:				
Last Name	First Name	MI	DOB	Telephone #
Guardian/Caregiver/Foster Parent:				
Last Name	First Name	MI	DOB	Telephone #

Contact Information:			
Street Address	Apt/Unit #	City/State/Zip Code	Telephone #

Child(ren):					
Last Name	**First Name**	**DOB**	**Last Name**	**First Name**	**DOB**

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1. I am the parent/legal guardian/foster parent of the child(ren) named above, and I have the authority to enter into this agreement on his or her behalf.

   INITIAL: _____

2. I understand that some participating agencies may have additional confidentiality requirements and may ask me to sign an additional release prior to services.

   INITIAL: _____

3. I understand that State and Federal laws protect my privacy rights and the privacy rights of my child and information will not be shared without my express permission. By signing this agreement, I understand that I am giving my permission to exchange information about my child among the Providers/organizations/agencies I have checked above.

   INITIAL: _____

4. I release, discharge and agree to hold harmless the agencies/entities and their employees and agents from any and all liability arising out of the release, disclosure, and/or sharing of information authorized by this Agreement.

   INITIAL: _____

5. I agree to allow representatives of the above-listed agencies, for the purpose of evaluating coordination and effectiveness of services provided through the Wellness Network, to share information regarding my child's participation in the Wellness Network, including the effectiveness of the services/programs in which my child participates. I further understand and agree that information shared about my child at Wellness Network meetings with all participating agency representatives will be shared without my child's name attached.

   INITIAL: _____

6. I have read the above description and agree to allow information about my child, as noted above, to be shared among the agencies.

   INITIAL: _____

7. I understand that I may change or cancel my consent to this information sharing at any time by informing the Wellness Network Provider in writing.

   INITIAL: _____

This consent is effective from the date of signature through _____.

Parent/Legal Guardian Signature	**Date**