Parent Guardian Release of Information for Taylor County Mental Health Services

Date of Referral: _____ Date Received (office use):_____

Student: _____ Preferred Name: _____

Student DOB: _____ Ethnicity: _____ Gender: _____

Grade: _____ School: _____

Parent/Guardian Name: _____ Relationship to Student: _____

_____

Address City State Zip

Phone: Home: _____ Work: _____

Mobile: _____ Other Phone: _____

Preferred Number of Contact (please check): ☐ Home ☐ Mobile ☐ Work ☐ Other

Primary Insurance: _____ Primary Policy #: _____

Current Concerns for referral purposes Please check all that apply:

Behavioral Concerns ☐ Emotional Concerns ☐ Academic Concerns

☐ Social concerns ☐ History of mental health diagnosis:_____

Preferred Agency: (Please list in order from 1-6 agency preference and we will try to coordinate based on your choices. 1= first preference 6= last preference)

__ A New Dawn, A New Beginning __ Apalachee __ Community Wellness

__ Panhandle Therapy __ Florida Therapy __ Disc Village(substance abuse counseling)

__ No Preference

Consent of Treatment, Communication, and Coordination of Care:

By signing, I understand that my child's counseling information is confidential. I understand that I am giving permission for the Taylor County School Mental Health Providers and Taylor County Schools to release any protected health information (PHI) to each other and the agencies listed regarding treatment, payment, and coordination of care. Understand that you have the right to rescind this release at any time by contacting the Taylor County School Mental Health Coordinators.

By signing, you are acknowledging that you are the current custodial parent or guardian:

Parent/Guardian Signature: _____ Date: _____

2021-2022 Parent Guardian Release of Information for Taylor County Mental Health Services

Dear Parent/Guardian,

Your child has been referred to the Taylor County Mental Health Coordination Program. With your permission you are allowing us to gather information from school staff to coordinate appropriate care. We will help to coordinate services that can be conducted during school hours, if preferred. The goal is to establish individual and/or group sessions to address the needs of your child. These services can only be provided with permission, as information will be shared with professional therapists to provide the best service possible. Please note mental health information is confidential and the therapist we coordinate with are licensed or under strict professional supervision to obtain their license, This means we all uphold a strict professional and ethical standard to provide the best services. The only exception to confidentiality is indications of self-harm or harming others. If you agree to let your child participate in the school mental health program, please complete the attached form.

We coordinate with several different therapists and/or agencies that serve the local area. Please feel free to review the agencies listed or seek services on your own.

Here is a list of agencies that we coordinate with. We will be glad to coordinate the services; however, here is the contact information if you would like to research ro contact them on your own.

A New Dawn, A New Beginning (850) 329-5776

Community Wellness (850) 643-1033

Florida Therapy Services (850) 681-6001

Apalachee Mental Health Services (850) 584-5613

Disc Village(substance abuse counseling) (850) 838-2525

Panhandle Therapy (850) 674-8888