ATTACHMENT C-2: SUPPORTING DOCUMENT FOR PARTNERS/FATHERS

C.2.1 Consent Form

Attachment C-2.1

Consent Form

SAMPLE CONSENT FORM

I, _____, authorize
(NAME OF CONSUMER)

_____
(NAME OR GENERAL DESIGNATION OF PROGRAM MAKING DISCLOSURE)

to disclose to:

1.
2.
3. _____
(NAME OF PERSONS OR ORGANIZATIONS TO WHICH DISCLOSURE IS TO BE MADE)

the following information:

_____
(NATURE OF THE INFORMATION, AS LIMITED AS POSSIBLE)

The purpose of the disclosure authorized herein is to:

_____
(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

_____
(Date) (Print Name) (Signature of Consumer)

_____
(Date) (Print Name) (Signature of Parent, Guardian or Authorized Representative when required)

The following notice must accompany a disclosure of information concerning a consumer in alcohol/drug abuse treatment, made to grantee organization with the consent of such consumer. This notice is not to be altered in anyway.

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CONSUMER IN ALCOHOL OR DRUG ABUSE TREATMENT STATEMENT

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Informed Consent for Data Collection

The purpose of your participation in this data collection activity is to collect information to assess the effectiveness of treatment services received by you (and/or your children) here at _____. You and/or your child's participation is encouraged but
(Name of Treatment Agency)
completely voluntary. The expected duration of this data collection activity is approximately fourteen months. You and/or your child have the right to stop participating in this data collection activity at any time without discontinuing your treatment services for yourself or your child.

The risk in participating in this data collection is seen as minimal. However, because some questions are of a sensitive nature, you or your child may feel uncomfortable. To minimize this risk, precautions have been taken to select questions that are frequently asked in Substance Abuse treatment programs. In the event you or your child becomes uncomfortable answering any of these questions, there will be clinically trained staff to provide any necessary support services.

If you have any questions regarding this data collection activity, please contact

_____
Name/Title/Address/Phone Number

By signing below, I am voluntarily agreeing to have myself and or my child participate in this data collection activity.

_____
Name (Print Name) Signature of Child Date

_____
Name (Print Name) Signature of Parent, Guardian or Authorized Rep. when required Date

_____ _____
Signature of project staff/witness Date

This form is valid until _____. (Insert Date)