State of Indiana

Dual Status Assessment Team Release

Informed Consent to Release and Exchange of Information

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby authorize the following agencies, individuals, or entities, to release, request, receive, and/or share information concerning the above named child among the members of the Dual Status Assessment Team appointed by court order for the specific purpose of 1) assessing the needs of the above named child and 2) to make a written recommendation regarding the dual status of the child and recommended treatment and services, specifically (check all that apply):

\_\_\_\_ Indiana Department of Child Services

\_\_\_\_ Juvenile Court/Probation Officer

\_\_\_\_ Court appointed Dual Assessment Team Facilitator

\_\_\_\_\_ the above named Child, if Court deems age appropriate

\_\_\_\_\_ the above named Child’s attorney

\_\_\_\_\_ the above named Child’s parents, guardians, or custodians

\_\_\_\_\_ the above named Child’s Parents’ attorneys

\_\_\_\_\_ the Prosecuting Attorney

\_\_\_\_\_ the DCS Attorney

\_\_\_\_\_ the CASA and/or Guardian ad Litem

\_\_\_\_\_ the authorized representative from the Department of Corrections

\_\_\_\_\_ the authorized representative from the above named Child’s school

\_\_\_\_\_ the above named Child’s therapist

\_\_\_\_\_ the above named Child’s foster parents

\_\_\_\_\_ the authorized representative from any service provider appointed by the team or by the juvenile court

This consent to release information will be used for the sole purpose of assisting in the assessment of services to be provided to the above named child either in a pending delinquency or CHINS proceeding, or both, and for the development of a recommendation to the Court as agreed upon by the court appointed Dual Status Assessment Team. This consent to release does not authorize the re-release of said information or the use of such information for any other purpose.

I understand that the information subject to release by my consent may include confidential information otherwise protected from unauthorized disclosure by Federal and State Laws, Rules, and/or Regulations.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall be valid for 180 days from \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

A copy of this document will have the same force and effect as the original.

I HAVE READ (OR HAVE HAD READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONDITIONS.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Child’s Signature (when appropriate) Date Witness Name Printed Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

Parent/Guardian Signature Date Witness Signature Date

Revocation of Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_