Haverhill Public Schools

HAVERHILL PUBLIC SCHOOLS
CONSENT TO SHARE INFORMATION WITH COMMUNITY-HEALTH PROVIDERS

Student's Name: _____ D.O.B.: _____

School: _____ Grade: _____

- I consent to Haverhill Public Schools ***electronically*** sharing referral information including my child's:
  - Name, date of birth, grade and HPS school my child attends.
  - Information about the difficulties my child is experiencing that may be relevant for the referral.
  - Information about how to contact me, when is best to contact me, and my preferred language, as well as information about my child's health insurance so that the mental health agency can contact me to begin services.

  with: *"Beth Israel Lahey Health Behavioral Services", "Family Services of the Merrimack Valley", "St. Ann's Home", "Sevita/Mentor South Bay", "Cartwheel" and "Children's Family & Friend Services/JRI"* for the purposes of establishing mental health services for my child.

- I consent to have *the agencies named above* exchange information with Haverhill Public Schools both verbally and in writing about the status of this referral for mental health services.

- I understand that I may refuse to sign (and can revoke) this consent. I understand that Haverhill Public Schools will not share any further information with community-based providers after the date that I withdraw my consent.

- I understand that neither *the agencies above* will condition my treatment/services or payment of my bills on my decision to sign this referral consent form.

- I understand that *the agencies above* have agreed to protect the privacy of this information consistent with state and federal privacy laws.

- I understand that, upon my request, I will receive a copy of this signed form.

- I have read and agreed to the terms above.

Parent/Legal Guardian Signature: _____

Student Signature (if over 18): _____

Parent/Legal Guardian or Student Name (if student is over 18) [please print]:

_____ Date: _____