

# Authorization for Sharing Information at the Family Justice Center

Thank you for visiting the Family Justice Center (FJC) today. Your **safety** and **confidentially** are of utmost importance to us. You are not required to give your real name today. To ensure you receive the services at the Family Justice Center as quickly as possible, to insure proper coordination, and to avoid some repetitive information, you may want to give permission for the FJC staff to share information to the on-site partners that you select.

The list of partners and the services they provide are listed on the back of this form and those services will be explained to you by our intake specialist. Only information that you approve will be shared with our on-site community partners.

The partners of the Family Justice Center are required to comply with laws regarding mandatory reporting of suspected abuse or neglect of children or elders or if there is danger to you or others.

If you agree for the FJC to share intake information please initial appropriate boxes on the attached form.

*You will continue to have access to services of your choice at the Family Justice Center if you chose not to consent to on-site information sharing. This consent can be revoked at any time by verbal or written request.*

We are here to serve you!

# Consent Form for Sharing Information at the Family Justice Center

I, \_\_\_\_\_, consent to sharing the following information:

(Please **initial** the lines of **your choice**)

\_\_\_\_\_ Acknowledgment that I have received services at the FJC

\_\_\_\_\_ Psychological Reports

\_\_\_\_\_ Civil Legal documents

\_\_\_\_\_ Advocate Case notes

\_\_\_\_\_ Child Protective Services Reports

\_\_\_\_\_ Other: \_\_\_\_\_

Between the following community partners: (Please **initial** the lines of **your choice**)

\_\_\_\_\_ FJC Intake Team/Clergy

\_\_\_\_\_ Wellspring Case Managers

\_\_\_\_\_ Wellspring Counselors

\_\_\_\_\_ Wellspring Child Advocate

\_\_\_\_\_ FJC Attorney

\_\_\_\_\_ Legal Services of North Louisiana

\_\_\_\_\_ District Attorney's Victims Services Advocate

\_\_\_\_\_ Office of Family Support

\_\_\_\_\_ Assistant District Attorney

\_\_\_\_\_ DV Response Unit/FJC –On-site Law Enforcement

\_\_\_\_\_ PHSC Medical Clinic

\_\_\_\_\_ Child Protective Services Agency (OCS)

**Are there any exceptions within the noted Agencies you want to make?**

<b>Name</b>	<b>Agency</b>	<b>Job Title</b>

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**For the Purpose of:**

\_\_\_\_\_ Coordinated response of the agencies to my case Other: \_\_\_\_\_

**Do you want information about services your children received shared among the above agencies as well?** \_\_\_\_\_ **Please list their names and ages below:**

\_\_\_\_\_

<b>Client Signature</b>	<b>Date Signed</b>	<b>Expiration Date (up to 1 year)</b>

		<b>*You may revoke your consent without losing services at anytime.</b>
<b>Witness Signature</b>	<b>Date Signed</b>	