FAMILY COUNSELING SERVICE OF THE FINGER LAKES, INC.

671 South Exchange Street ● Geneva, New York 14456
Telephone (315) 789-2613 ● Fax (315) 789-2524
TTY (800) 662-1220
Barbara Pierce-Morrow, MSM, CASAC, FDC, President/CEO

To: Family Counseling Service of the Finger Lakes Fax: 315-789-2524

Referral Source (Agency):_____

Reason for Referral:_____

Date of Referral:_____ Referral Source Contact Name:_____

Telephone:_____ Ext._____

Client Name:_____ Client D.O.B._____

Address:_____

Telephone: (Home)_____ (Cell)_____ (Work)_____

Has referral been discussed with family? ☐(yes) ☐(no) ****Please include a signed Release of Information for the client being referred (see below)***

Family Composition

Name:	Relation to referred	D.O.B.

Protective factors, strengths and other resources involved with family (List): _____
_____
_____

Disclosures, if any (include whether made, to whom and when, what disclosed, alleged offender):_____
_____

Other pertinent information: Fill in or attach other documentation (e.g. any mental health diagnosis, case/court status and findings, medical exam, psychological, any pending OVS claim):_____
_____

Referral is: ☐(voluntary) ☐(court ordered) Is any future court activity anticipated? (If yes, explain)_____
_____

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Release of Information Form

READ FIRST: Family Counseling Service of the Finger Lakes, Inc. (FCSFL) must keep information about you private. The only time your personal information should be shared is when you would like us to do so for specific services or if we are compelled by law or court order.

- You never have to agree to share your information. We will still provide services even if you do not sign the release. Your treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon you signing this release.
- If you would like FCSFL to share information about you, use this form to give instructions about what you would and would not like to have shared and with whom you would like the information to be shared.
- Before you sign this, someone at FCSFL will discuss your goals/needs, your choices for how to meet those and the pros and cons of having us share the information for you.
- You can change your mind about what you would like to have shared at any time and we will update this form to reflect your decision.
- You understand that the disclosure of information does relate to mental health treatment.
- FCSFL is prohibited from redisclosing such information without your authorization unless permitted to do so under federal or state law. You understand that even if you do not sign this form, FCSFL may be required in certain circumstances to disclose information about you, including about your mental health, if the law

This Release of Information request will authorize FCSFL to exchange pertinent information relevant to the assessment, treatment and support of:

_____ - _____
Name of Person date of birth

To: _____
(Person and/or Agency)

☐Advocacy ☐Case Management ☐Therapy

Specific Information to be exchanged:

- ☐ Medical Record from _____ to _____
- ☐ Entire Medical Record
- ☐ Treatment Update
- ☐ Other: _____ (please specify)

I understand this includes mental health information _____ (Please initial)

Via the following methods: ☐ in person ☐ phone ☐ fax ☐mail ☐ e-mail ☐ text ☐ other: _____

☐By checking this box, I acknowledge understanding that once the information is shared by FCSFL:

- Others will know that I have worked with FCSFL,
- Others might try to get more information about me from FCSFL, and
- The person/agency receiving my information might share it without asking me first.

Information will be communicated in a professional manner to protect confidentiality. Information released is restricted to the above named person/organization/program and may not be duplicated without my permission. This release form is valid for one year including up to thirty days after termination from date signed unless I revoke it in writing. I also understand that I may revoke this consent at any time with the exception of action that has already been taken in reliance upon it.

Client's Signature:_____ Date: _____

Print Client's Name: _____

If the information to be exchanged is regarding a minor, I attest that I am the custodial parent or guardian of the above child and have the legal authority to authorize this release.

Parent/Guardian Signature:_____ Date: _____

Print Parent/Guardian Name: _____Parent/Guardian Date of Birth: _____

Witness Signature _____ Print Witness Name _____

As we exchange information, FCSFL wishes to emphasize that it is strictly confidential, and under federal regulations (Code of Federal Regulation 42, Part 2), it may not be disclosed by or transferred from you to anyone else without the client's further consent. Hence, do not release this material to any other party, including the client, without written consent of the client. In addition, this information is intended only for the use of professional persons capable of understanding and acting on it. We assume no responsibility if this information is conveyed to individuals not professionally prepared to interpret and use it, including the client.