Consent To Receive Or Disclose Information

Name _____ Date of Birth _____

The information will be disclosed to and used by Tamassee DAR School, P.O. Box, 8, Tamassee, SC 29686.

Purpose of Request: _____ Residential Placement Needs _____ Educational Needs

The following information is to be received/disclosed:

_____ School Records
_____ Medical Records
_____ Mental Health Information
_____ SC Department of Social Services Records
_____ Other: _____

I understand that information about my child may be received/disclosed with the following organizations/agencies:

- School:_____
- Medical Provider:_____
- Mental Health Provider:_____
- SC Department of Social Services: _____
- Other:_____

____ **Initials:** I understand this consent maybe used to provide two way communication (received & disclosed) between the above listed organizations or agencies and Tamassee DAR School for the development and implied care of the above named child.

____ **Initials:** I understand that I have the right to revoke this consent at any time by providing a written statement to my Tamassee DAR School contact, except to the extent that action has already been taken based on this consent and with the knowledge that it could inhibit my child's care.

____ **Initials:** I understand that I may inspect or obtain a copy of the information used or disclosed.

____ **Initials:** I understand that refusal or withdrawal of this consent may inhibit necessary care of my child, which may result in discharge or denial of service.

_____ _____
Signature of student or Legal Representative Date of release

_____ _____
If not student, relationship of legal representative to patient Date release will expire (not to exceed 1 year)

Revised August 2019

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

I, _____ (Name of requestor), at _____ Address (Street, City, State, Zip)

DOB _____, SS# _____, Medical Record # _____ authorize the release of my SCDMH health information, as specified below, for the following purpose: _____.

I authorize the release of the following information for the time period from: _____ to _____.

☒ Information from **all** SCDMH inpatient and outpatient facilities, centers, clinics, programs and offices

OR

☐ Information from (name of specific hospital): _____

AND **The information authorized to be released includes:**

- ☒ All information from above
- ☐ Diagnoses
- ☐ Clinical History & Evaluation
- ☐ Admission and Discharge Dates
- ☐ Individualized Treatment Plan Progress Summaries
- ☐ Discharge Summary (Summary of Treatment)
- ☐ Physician's Medication Orders
- ☐ History and Physical
- ☐ Psychiatric History and Mental Status Examination
- ☐ Consultant Notes
- ☐ Billing and Payment Information
- ☐ Written Summary (copy attached)
- ☐ Other: _____

This information should be released to:

Name: Tamassee DAR School

Address: PO Box 8

Tamassee, SC 29686

Telephone No.: (864) 944-3022

Relationship: Caregiver

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include alcohol/drug abuse and/or HIV/AIDS/ARC and other infectious disease information about me. I do not want the following information disclosed:

_____

This Authorization is valid for one year from my signing unless an earlier date, condition or event is specified here:

_____

I understand that information disclosed may be subject to re-disclosure by the entity named above. I may cancel this Authorization by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization, SCDMH cannot take back any use or release made with my Authorization, and SCDMH must keep records of my treatment. I understand that I may refuse to sign this Authorization and my refusal will not limit my access to SCDMH treatment or other services. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my Authorization. I have been given a copy of this Authorization.

Signature of Individual/Personal Representative	Printed Name	Date

Authority if signed by Personal Representative _____

Signature of DMH Staff releasing information	Printed Name	Method of Release	Date Released

Patient Identification

Tamassee DAR SCHOOL
Reaching for the stars

Financial Verification & Board Payment Approval

Student's Name:_____

Verification needed to complete this form:

- Last year's tax returns (for all income sources living within your household)
- Last two pay stubs for all working within your household
- Proof of income amount or lack of income

*I understand that my student's board payment will be set without a discount until all documentation are presented. If you do not have pay stubs or did not file taxes within the last year we will need an official verification notice from the IRS.

Please list income from all sources: *(Including child support, disability, Social Security benefits, etc)*

Income Type:	Annual Income Amount:
Total:	

- Please list any person(s) living in your household and dependent status:

I understand the information I have given will be used for the sole purpose of determining the amount of board payment for my student. I am stating that the information I have given is true. I agree to contact Tamassee DAR School if my financial circumstances change.

_____ _____

Parent/Guardian Signature Date

Office Use only-

Sliding scale amount:_____ *Additional discount approved?_____

Family able to contribute:_____

Monthly Board payment total:_____

Approved by:

_____ _____

Admissions Coordinator Date

_____ _____

Chief Programs Officer Date

Revised August 2019