Agreement for Services and Release of Information Form

Agreement for Services:

As an individual over the age of 18 or a Parent/Legal Guardian of a minor, I hereby authorize the Children's Cabinet, Inc. to provide services for myself or my family. I understand that by signing this agreement for services my family is a client of The Children's Cabinet. Therefore, our case file, case notes and case plans may be reviewed by the appropriate Cabinet staff member for the purpose of program compliance.

We understand that family information will be held confidential unless we consent to its release. By Nevada Revised Statute 432B.220, Children's Cabinet staff is required to report any accounts of child abuse/neglect, past or present, or any situations in which someone is threatening themselves or others with any sort of harm. Similarly, according to Nevada Revised Statute 200.5091-5095 Children's Cabinet staff is required to report any accounts of abuse, neglect or exploitation of senior citizens, past or present.

Signed (Self/Parent/Guardian):_____**Date:**_____ **Client(s) name**_____
Witness:_____

Release of Information:

READ FIRST: Before you decide whether or not to let The Children's Cabinet share some of your confidential information with another agency or person, staff at The Children's Cabinet or referring agency will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want The Children's Cabinet to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand: (please initial)

☒ That I do not have to sign a release form. I do not have to allow The Children's Cabinet to share my information. Signing a release form is completely voluntary.

☒ That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from The Children's Cabinet.

☒ That The Children's Cabinet and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

☒ The Research Confidentiality Policy – It is the policy of this organization that no identifying data pertaining to individual clients will be released to outside entities for research purposes.

I understand that this Release is valid when I sign it and that I may withdraw my consent to this Release at any time either orally or in writing.

I understand that The Children's Cabinet has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow The Children's Cabinet to release some of my personal information to certain individuals or agencies. I, _____, authorize The Children's Cabinet to share the following specific information regarding
Self/Parent/guardian
,_____, with the following:
Client(s) Name

Early Childhood Consultation – Program Specific Contacts:	**Community-Based Services (As Needed)**
_____ Private Childcare Provider (Director, Teaching Staff)	_____ State of Nevada DCFS (Juvenile, Welfare, Mental Health Services)
Name of Provider: _____	_____ Clark/Washoe County DFS (Juvenile, Family, Social Services)
_____ Special Education Consultant	_____ Child Find in _____ County
_____ Special Education Consultant – Service Evaluator	_____ Nevada Early Intervention Services (NEIS)
_____ Other:	
_____	

Information or records to be released and exchanged shall be limited to the following:

*Name, Address, Home & Work phone numbers
*Access for Children's Cabinet staff to meet with child in private while at the above mentioned agencies
*School attendance, social, and academic progress
*Date Services began with The Children's Cabinet
*Summary of services provided by the above mentioned agencies
*Results of referrals made
*Juvenile delinquency history Probation involvement
*Date child was reunified with parents
*Date services were terminated with The Children's Cabinet
*Attendance in programs
*Results of services received by client

Signed:_____**Date:**_____**Witness:**_____
Expiration Date:_____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____
Signed:_____ **Date:**_____ **Witness:**_____

*** Expiration should meet the needs of the client, which is typically no more than 6 months but may be shorter or longer**

The Children's Cabinet is a grant funded nonprofit that provides free community services. To meet our grant requirements, we collect basic demographic information about the children, families, and educators we serve. Please complete the section below. Your personal information will not be shared with any external agency without your written consent and will only be used to create summary data to understand who we serve.

Parent's First, Last Name:	
Number of Adults in your household:	
Number of Children in your household:	
Parental Martial Status:	
Yearly Household Income:	
Parent Signature:	

You can give this form back to your child's school, and they will send it to The Children's Cabinet along with the Referral Form & Release of Information. **If you are not comfortable sharing this information with your child's school**, you can email the completed form or details to Kim Cullen at KCullen@childrenscabinet.org.

Thank you,

Kim Cullen
Program Manager
Kcullen@childrenscabinet.org
775-843-1324

The Children's Cabinet
961 Matley Lane Suite 110
Reno, NV 89502