

**CONSENT FOR THE RELEASE OF CONFIDENTIAL MENTAL HEALTH
INFORMATION TO MULTI-SERVICE CONSORTIUM.**

I hereby authorize use or disclosure of the named individual's health information as described below.

CLIENT		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Telephone Number:	Client Number:	Date of Birth:

I authorize the TBS Consortium ("Consortium") and the following members of the Consortium:

- (1) County of San Bernardino/Department of Children's Services
- (2) County of San Bernardino/Department of Behavioral Health
- (3) Mental Health Systems, Inc. – TBS Program San Bernardino
- (4) Therapist - _____
- (5) School - _____
- (6) Other - _____

to communicate with and disclose to one another the following information:
(initial each category that applies)

- _____ my name and other personal identifying information;
- _____ initial and subsequent evaluations of my service needs by the Consortium and its members;
- _____ summaries of mental health assessment results and history;
- _____ summary of mental health services plan(s), progress and compliance;
- _____ attendance in mental health services;
- _____ discharge plan(s) for mental health services;
- _____ date of discharge from mental health services and discharge status;
- _____ school, educational testing, evaluations records
- _____ other: _____

The purpose of the disclosures authorized in this consent is to:
Enable the TBS Consortium and its members to evaluate my need for services from the consortium and its members, and provide and coordinate the Consortium's and its members' services to me.

This authorization will remain in effect:

- From the date of this authorization until _____, 200__
- Until the following event occurs: _____
- Date authorization was revoked: _____

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to the Consortium and its members. The revocation will be effective immediately upon receipt of my written notice, except that revocation will not have any effect on any action taken by the Consortium and its members in reliance on this authorization before it received my written notice of revocation.

I understand that the Consortium and its members that are authorized to exchange this confidential/privileged information may not use the information for other purposes or release the information to anyone else not covered by this release unless I authorize it or unless it is specifically required or permitted by law.

I understand that I have a right to refuse to sign and a right to limit the scope of this authorization. If I revoke this authorization, or refuse to sign at all, it will not affect my ability to access services from any of the Consortium members listed above.

I understand that I have the right to receive a copy of this authorization.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize the TBS Consortium to use or disclose my health information in the manner described above.

Signature of Client

Date

If the client is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

Signature of Personal Representative

Description of Authority

Date