George Junior Republic
IN INDIANA

I _____ acknowledge that I have received a copy of GEORGE JUNIOR REPUBLIC IN INDIANA'S NOTICE OF PRIVACY PRACTICES and had the opportunity to ask questions.

_____
Name of Client

_____
Signature of the client or the client's personal representative if the client cannot make health care decisions for him/herself.

_____
Witness Signature

_____
Date

_____
Date

George Junior Republic
IN INDIANA

ACKNOWLEDGEMENT OF GOALS AND EXPECTATIONS

I acknowledge that my home-based worker has reviewed with me the reason for the referral from DCS/probation and has discussed the following:

1. Cancellation and No Show policy
    A. Three no-shows and you may be considered non-compliant and may be discharged unsuccessfully from the GJR program.
    B. You will be discharged if there are excessive cancellations. You will receive a warning if cancellations become an issue and you will be given an exact number of cancellations that will be tolerated based on number of days/hours GJR works with you.

2. Expectation of the intensity of service

3. Contact Information:

    _____
    _____
    _____

4. Safety Concerns - are there any safety concerns in your home (i.e. weapons, bed-bugs, communicable diseases?

    _____
    _____
    _____

5. Are there any cultural/religious considerations you want me to be aware of?

    _____
    _____
    _____

I understand DCS/Probation expects the following general goals to be addressed.

1. _____
    _____
2. _____
    _____
3. _____
    _____

Please provide goals you hope to accomplish.

4. _____
   _____
5. _____
   _____
6. _____
   _____

I also understand more specific goals may be added to support the general goals listed above.

_____	_____
Printed name of client	Date
_____	_____
Signature of client	Date
_____	_____
Signature of client	Date
_____	_____
Signature of client	Date
_____	_____
GJR Home-based worker	Date

George Junior Republic
IN INDIANA

CLIENT RIGHTS

Each client of George Junior Republic in Indiana is entitled to certain rights as defined under the law. Employees of George Junior Republic in Indiana are responsible for ensuring that each client's rights are respected. At no time is an employee permitted to take any action that violates the rights of a client and each employee is responsible to read and understand the client rights statement.

- A client and the client's family may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age, gender identity, or sex.
- A client has the right to be safe, nurtured and protected from abuse and neglect.
- A client has the right to live in a supportive, stable home.
- A client and their family have the right to be treated with fairness, dignity, and respect.
- A client and their family have the right to be informed of the guidelines and expectations of the program.
- A client and their family have the right to practice the religion or faith of choice, or not to practice any religion or faith.
- A client has the right to appropriate medical and behavioral health.
- A client has the right to humane rehabilitation and treatment.
- A client has the right to an individualized, written treatment plan to be developed promptly after admission.
- A client has the right to be free from excessive medication.
- A client may not be subjected to unusual or extreme methods of discipline, which may cause psychological or physical harm to the child.
- A client has the right to appropriate seasonal attire.
- A client and the client's family have the right to lodge a grievance with the program *for an alleged violation of specific client or civil rights* without fear of retaliation.
- A client and their family have the right to confidentiality of records.
- A client may not be deprived of specific client or civil rights.
- A client's rights may not be used as a reward or sanction.
- A client and their family has the right to contact and consult with legal counsel and private practitioners of the client's choice at the client's expense.

We have received and reviewed our rights with the George Junior Republic in Indiana, Inc. staff.

CLIENT SIGNATURE	DATE
PARENT OR GUARDIAN (IF APPLICABLE)	DATE

George Junior Republic
IN INDIANA

CLIENT GRIEVANCE PROCEDURE

Each client and parent or guardian has the right to lodge grievances without the fear of retaliation. The Client Grievance Procedure within George Junior Republic in Indiana is as follows:

1. If a problem, question, issue or situation arises regarding the client and/or family's treatment, it should first be discussed with the client's George Junior Republic in Indiana staff.

2. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the staff member, it should then be discussed with the George Junior Republic in Indiana direct supervisor. The supervisor is a managerial staff person and the direct supervisor of the staff.

3. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the supervisor, it should then be discussed with a director of Indiana.

4. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with a director, it should then be discussed with the Vice President of Indiana.

5. If a problem, question, issue or situation arises regarding the client and/or family's treatment and cannot be satisfactorily resolved with the George Junior Republic in Indiana Vice President, it should then be discussed with the Human Resources Officer.

6. Also, please keep in mind that at any time, a client, youth, parent or guardian is encouraged to discuss any problems, questions, issues or concerns regarding the George Junior Republic in Indiana Program with the Probation Officer or Caseworker from the referring agency.

CLIENT SIGNATURE	DATE
PARENT OR GUARDIAN (IF APPLICABLE)	DATE

George Junior Republic
IN INDIANA

GEORGE JUNIOR REPUBLIC IN INDIANA
CONSENT TO RECEIVE SERVICES

1. I, as the client (the term "I" and "client" shall mean the patient receiving the Services or the parent or legal guardian who is executing this Consent on behalf of the patient), understand that George Junior Republic in Indiana ("GJR") provides an array of services, such as home-based and office-based individual, group or family therapy, case-management, diagnostic and evaluation testing, assessments, random drug screens, independent living as well as other interventions as outlined by referral sources. In-person, virtual, or telephonic services will be utilized when appropriate. I understand that the client and/or client's family will be provided services on an ongoing basis as defined in the client's treatment plan ("Services") and I consent to the provision of Services. I understand such Services will be provided by an appropriate level of direct care worker as defined by Indiana state service standards regarding scope of education, training, and experience.

2. I understand that communication through social media including, but not limited to, Facebook, encrypted email, Skype, oovoo, MySpace, Zoom, Teams, Twitter, Duo, Google+ and text messaging may be used and that every attempt will be made to avoid, limit and protect disclosing personal health information [PHI].

3. I understand that the following information has been explained to me before the commencement of Services:
    a. Client's status giving rise to the proposed Services
    b. Proposed Services to be rendered to the client.
    c. Expected outcome of such Services.
    d. Material risks of such Services.
    e. Reasonable alternatives to Services.

4. I understand that I have a right to withdraw this consent for Services at any time by notifying, in writing or verbally, GJR.

5. I understand GJR may terminate services by notifying the client verbally or in writing, of the reasons for termination, and that GJR will refer the client for alternate treatment services if requested or required.

6. I understand that if emergency medical care or treatment is needed for the client I consent to GJR obtaining such emergency medical care or treatment. I understand that I will be financially responsible for any such emergency medical care or treatment obtained by GJR for the client.

7. I have had sufficient opportunity to discuss the client's condition with a representative of GJR. I understand the potential benefits of the Services and all of my questions have been answered to my satisfaction.

8. I understand the contents of this consent form. I understand that I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction.

9. I acknowledge that I have adequate knowledge upon which to base an informed consent to the Services.

_____ _____ _____
CLIENT SIGNATURE DATE OF BIRTH DATE SIGNED

_____
Printed Client Name

_____ _____
PARENT / LEGAL GUARDIAN SIGNATURE DATE SIGNED
(Parent or Legal guardian must sign if Patient is under the age of 18 years)

_____
Printed Name of Parent/Legal Guardian

_____ _____
WITNESS SIGNATURE DATE SIGNED

_____
Printed Name of Witness

George Junior Republic IN INDIANA

RESPONSIBLE PARTY CONFIRMATION FORM

George Junior Republic of Indiana ("GJR") provides home-based, group home, office-based, and other consultation services to clients of GJR. Due to the nature of GJR's services, there may be times when a person other than client's parent has been assigned responsibility for making health care decisions for a client. Such person may be a guardian, health care representative, or special advocate, appointed by the court, or other person otherwise authorized to make decisions on behalf of the client (the "Responsible Party"). To ensure GJR communicates with and obtains consent from, the proper person regarding the client, this form notifies GJR when a person other than the parent has been established as a Responsible Party.

In addition to completing this form, when there is a Responsible Party, legal documentation confirming the authority of the Responsible Party must be submitted to GJR. An example of such legal documentation is a copy of the court order establishing the guardianship or representation. GJR retains the right to withhold treatment or otherwise withhold communication about the client to the person, unless GJR receives such legal documentation supporting the Responsible Party's authority.

Section 1. Client Information

Name of Client: _____

Date of Birth: _____

Section 2. Confirmation of Responsible Party

Please check the applicable box:

☐ I am the parent of the client and there is <u>not</u> currently a Responsible Party appointed for the client.

If this box is checked, complete Section 3 and Section 5.

☐ I am the parent, but do not have the authority to make health care decisions on behalf of the client due to the appointment of a Responsible Party.

If this box is checked, complete Section 3, Section 4 with information about the Responsible Party, and Section 5.

☐ I am the Responsible Party and have the authority to make health care decisions on behalf of the client due to my appointment as (check the applicable circle):

- o Judicially-appointed guardian
- o Health care representative
- o Court appointed special advocate

- Other person authorized to make health care decisions on behalf of the client. Please describe _____

  If this box is checked, complete Section 4 with your information and Section 5.

Section 3. Parent Information

Mother
Name of Mother: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____

Father
Name of Father: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____

Section 4. Responsible Party Information

Name of Responsible Party: _____
Date of Birth: _____
Home Address: _____
Phone Number (Home): _____
Phone Number (Cell): _____
Name of Employer: _____
Phone Number (Work): _____
Relationship to Client: _____
Effective Date of Status as Responsible Party: _____
Termination Date/Event of Status as Responsible Party: _____

Please also provide a copy of the legal documentation confirming the authority of the Responsible Party.

Section 5. Attestation and Signature

I have read and understand the above information. By signing this form, I attest that I have completed this form to the best of my knowledge regarding the person who has the legal authority to make decisions on behalf of the client.

Name of Parent/Responsible Party (Print): _____
Signature of Parent/Responsible Party: _____
Date: _____

GJR Staff Signature: _____
Date: _____

GJR Staff Use Only
Legal Documents Supporting Responsible Party Provided? Y / N
Copy of Legal Document Placed in Client Record? Y / N

George Junior Republic
IN INDIANA

VISITATION GUIDELINES
HOME-BASED PROGRAMS AT GEORGE JUNIOR REPUBLIC

The purpose of professionally supervised visits is to ensure that the child is physically and emotionally safe so that he or she is free to build a positive relationship. The following guidelines are in place to ensure that this goal can be met. They are directed primarily toward the welfare of the child, yet also address the feelings and concerns of the family.

1. The staff is present to safeguard the child's well-being; to do this he or she must be able to observe all interactions and hear all conversations. If a conversation is inaudible at any time during the visit, the staff may ask the speaker to raise the volume of their voice. It is also the staff's responsibility to look over or through any personal items passed to the child during visitation to check the item for appropriateness.

2. The staff is available to provide visiting adults with feedback on how their words and actions can help their child during visits. Staff will intervene as deemed appropriate to model, coach, explain, or assist with caregiving. Staff will present educational material/curriculum to the visiting caregiver to help increase skills. Homework may be assigned. Visitation notes will be kept throughout the visit, sent to the referral source, and are available for review with their facilitator.

3. Because negative comments about other family members or circumstances cause stress for the child, such complaints should not be voiced during a visit. Discussion of other emotionally sensitive topics including, but not limited to divorce, future custody arrangements, negative comments about the foster parents and other service providers, precipitating factors for visitation, treatment team decisions, and court proceedings. When in doubt, the adult should check with the staff before the visit.

4. Additional visitors must be approved by the DCS Case Manager.

5. No one may threaten or harm the child or George Junior Republic in Indiana staff. If this occurs, the visit will be stopped immediately, the children will be removed from the room, and the proper authorities will be notified. George Junior Republic in Indiana does not permit the use of corporal punishment as a form of discipline during visitation.

6. Parents, caregivers or adult visitors participating in the visitation are not permitted to consume alcohol and/or illegal substances. Parents, caregivers or adult visitors may be required to submit to a Urine Drug Screen, Oral Drug Screen and/or a Breathalyzer upon request. Refusal to do so will lead to that individual not being allowed to participate in the visitation. If the breathalyzer tests positive for alcohol or if any person appears to be under the influence of illegal drugs or alcohol, the visit will be cancelled. You are not permitted to leave the visitation space in order to smoke as you are responsible for your child at all times. If this occurs and your child is left unsupervised, your visitation will be terminated.

7. No weapons, including pocket knives, are allowed during visitations.

8. All parties involved in the visit are responsible for arriving on time for each visit and for notifying the staff if they are going to be late or must cancel a visit. If one party is 15 minutes late and the staff has not been notified, the other party will be sent home. You must give 24 hours' notice of cancellation or the visit will not be rescheduled. Before cancelling, ask yourself, "Would I be taking care of my child today if he/she were in my care?" If the answer is "yes" then you need to attend the visit. If your staff is unable to attend the visit, we will find a replacement or reschedule, but please understand this may alter the time of the visitation.

9. If a client is transporting their child during a semi-supervised visitation, proof of a valid driver's license and auto insurance must be provided to the staff and/or referral source.

10. The staff must remain in the same room with the family at all times during a fully supervised visit, and the child must be visible to the staff at all times. Other levels of supervision during visitation may be requested by the referral source.

11. The visit is a time to bond with your child and receive important case management services. Cell phones and pages are not permitted during visitation. Once you enter visitation, please turn off/vibrate all such equipment, unless discussed previously with your staff.

12. A consistent visitation schedule must be established, based on the parent, caregiver, referral source and staff. Once a schedule is established prior notice of one week must be given to the staff to make modifications and provide accommodations to things like conflicting work schedule, medical appointments, and other obligations.

13. The visiting parent/caregiver is responsible to provide diapers, wipes, formula (for infants), and food and drink (for toddlers). If your child has a favorite food or cup you may also want to provide it, but staff does not require you to do so at the onset of services. Staff may be able to provide these items for you, initially; however, this must be discussed and agreed upon before visitations begin.

14. If available, staff provides each family with their own visitation room at a community location. You are responsible for cleaning up messes made and the daily upkeep of this space.

15. Other: _____

Failure to follow these guidelines could result in early termination of the visit. The staff reserves the right to intervene at any time during the visitation. Interventions are utilized to

protect the safety and emotional well-being of children and to maintain respect for all visiting parties.

Your signature below indicates that you have read and understood these guidelines and that you agree to follow them during visits.

_____ _____

Parent/Caregiver or Visiting Adult / Date Parent/Caregiver or Visiting Adult / Date

_____

George Junior Republic Staff / Date

George Junior Republic
IN INDIANA

TRANSPORTATION CONSENT AND RELEASE

I, the undersigned, do hereby consent to the transportation of _____ (the "Client" [s]), by George Junior Republic in Indiana, Inc. ("GJR"), its agents, therapists, employees, and independent contractors (each individually and collectively, "GJR Representatives").

By signing this Form, I hereby release and agree to hold harmless GJR and GJR Representatives, from any and all claim(s) stemming from or in any way relating to the transportation of the Individual, whether the Individual is being transported to or from GJR by a GJR Representative at the time the client(s) is allegedly injured as a result of said GJR Representative's alleged negligence or otherwise allegedly tortuous conduct. I understand and acknowledge this Form will be in effect regardless of the nature or seriousness of any and all injuries which may be sustained by the client(s) while or as a result of the client being transported by a GJR Representative.

Prior to signing this Form, I have had sufficient opportunity to independently consider and/or to consult with an attorney to ask questions regarding the meaning and significance of this Form. I understand and agree to all of the terms of this Form and acknowledge that in so doing I have not relied upon any statement, explanation or promise by any GJR Representative, with regard to the meaning, scope or effect of this Form.

_____
(Printed Name of Individual or Parent/Guardian on behalf of Individual)

_____
(Signature of Individual or Parent/Guardian on behalf of Individual) (Date)

_____
(Printed Name of Witness)

_____
(Signature of Witness) (Date)

George Junior Republic
IN INDIANA

RELEASE FORM - Transportation/Group Activities

I, _____,_____ do hereby consent to
(Name of Client) (Date of Birth)
involvement in group tasks and transportation with other youth in the George Junior Republic programs.

_____ _____
(Signature of Client, Parent, or Guardian) (Date)

_____ _____
(Signature of Witness) (Date)

The Department of Child Services or Juvenile Probation is the guardian of

_____ and consents to this youth participating in groups and/or transportation with other youth involved in the George Junior Republic program.

_____ _____
(Signature of Parent/Guardian/Referral Agency) (Date)

_____ _____
(Signature of Witness) (Date)

George Junior Republic
IN INDIANA

GJR Home-Based Services Initial Assessment

Date of Assessment: _____

1. Life/Family Domain

Mother's Name:	Education Level:
Guardian/Co-parent's Name:	Education Level:
Father's Name:	Education Level:
Guardian/Co-parent's Name:	Education Level:
Child's Name:	Education Level:
Child's Name:	Education Level:
Child's Name:	Education Level:
Child's Name:	Education Level:
Child's Name:	Education Level:

Any criminal history for family members? ___ Yes ___No If yes, please explain:

Family strengths:

2. Health Domain

For all family members, please list any physical or mental health diagnoses, disabilities, current symptoms/treatment and prescribed medications:

Name:	Diagnoses:	Current Symptoms/Treatment:	Medications:

3. Trauma Domain (abuse, neglect, separation, loss, suicide, homicide, death, natural disaster, violence, etc.)

Any parental history of childhood trauma? ___ Yes ___No If yes, please explain:

Any child history of trauma? ___ Yes ___No If yes, please explain:

Any other history of trauma:

How has trauma impacted life functioning?

4. CAGE-AID:

	Name:	Name:
1. Have you ever felt you ought to cut down your drinking or drug use?	Y/N	Y/N
2. Have people annoyed you by criticizing your drinking or drug use?	Y/N	Y/N
3. Have you felt bad or guilty about your drinking or drug use?	Y/N	Y/N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get ride a hangover (eye opener)?	Y/N	Y/N

5. Other Important Information:

George Junior Republic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I, _____ do hereby consent
(Name)

and authorize unrestricted communications between
_____ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

1. Assessment/diagnosis in treatment/counseling
2. Attendance/participation in treatment/counseling
3. Progress and prognosis in treatment/counseling
4. Verbal Communication
5. Progress notes
6. Discharge summary/completion letter
7. Information relevant to facilitation of compliance with GJR Program
8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _____

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:_____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under

the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

(Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

Signature of Client (if 13 year or older) Date

Signature of Personal Representative* Date

*Nature of Relationship between Personal Representative and Client, where applicable

Signature of Witness Date

Printed Name of Witness

George Junior Republic
IN INDIANA

AUTHORIZATION/CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I, _____ do hereby consent
(Name)

and authorize unrestricted communications between
_____ (Name of agency or person providing or receiving information)

and George Junior Republic/George Junior Republic in Indiana.

This will include the following information regarding the Client:

8. Assessment/diagnosis in treatment/counseling
9. Attendance/participation in treatment/counseling
10. Progress and prognosis in treatment/counseling
11. Verbal Communication
12. Progress notes
13. Discharge summary/completion letter
14. Information relevant to facilitation of compliance with GJR Program

8. Continuing care plan
9. Education records
10. Assessments
11. Monthly Reports/Treatment plan
12. Other: _____

The purpose of and the need for this disclosure is (Check all that apply. For SUD Records, the disclosure will be limited to that information which is necessary to carry out the below described purpose):

____ To provide ongoing treatment/continuing care,
____ To obtain insurance or employment or government benefits,
____ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal disclosure on my behalf,
____ To coordinate treatment efforts with family/concerned persons,
____ Other:_____

I understand that:

- HIV – related information will not be released through this Authorization.
- If the Client's records relate to the diagnosis, treatment, or referral for treatment for a substance use disorder ("SUD Records"), the Client's SUD Records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient

Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations and any such disclosures must be limited to that information which is necessary to carry out the stated purpose of the disclosure.

- If the Client's records are SUD Records and I consent to the disclosure of SUD Records using a general designation, as authorized by 42 CFR Part 2, I may request and receive a list of entities to which my SUD Records have been disclosed under such general designation.
- I may revoke this Authorization, in writing, at any time, except to the extent that action has been taken in reliance on this Authorization. However, if the revocation is for SUD Records, the revocation can be provided orally.
- George Junior Republic in Indiana ("GJR") will not condition treatment, payment, enrollment or eligibility on my execution of this Authorization.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and be no longer protected by HIPAA. For SUD Records, GJR will include the following statement prohibiting unauthorized disclosure of such SUD Records:

  "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65."

- This Authorization expires automatically as follows:

(Specification of date, event, or condition upon which this Authorization expires. This Authorization will automatically expire the earlier of (a) the date, event, or condition specified above, or (b) the following applicable time period based on the type of record: (i) 180 days for mental health records, (ii) a period reasonably necessary to serve the above described purpose for SUD Records, or (iii) 60 days for all other health records)

Signature of Client (if 13 year or older) Date

Signature of Personal Representative* Date

_____

*Nature of Relationship between Personal Representative and Client, where applicable

_____

Signature of Witness Date

_____

Printed Name of Witness

George Junior Republic
IN INDIANA

INITIAL PAPERWORK Q&A

Consent:

1. What are "Reasonable Alternatives to Services"
    - Local mental health center therapy and treatments
    - Community support groups
    - Private insurance counseling
    - Private pay supervised visitation
    - Community-based mentoring programs
    - Medication-based treatment through psychiatrists and primary care doctors

2. What are Material risks of such Services?
    - Negative physiological and emotional symptoms
    - Interpersonal conflict
    - Behavioral changes

Responsible Party Form:

1. When is this required?
    - When you are not sure who is the responsible party. Usually this will be the parent, but could be DCS.