



# INFORMED CONSENT RELEASE OF INFORMATION

I, \_\_\_\_\_, have been fully informed about the Parent Partner Program and have been provided with an explanation of what the Parent Partner's responsibilities are while working as a mentor. I understand that the Parent Partner's is a mandated reporter. I understand the Parent Partner cannot provide childcare or transportation, or supervise visits with my child.

My rights and responsibilities have been explained to me. I understand that this is a voluntary program and that I can stop services, ask for changes to my program, or request a different Parent Partner by contacting the **Parent Partner coordinator at 515-269-3303**. My child welfare case will not be negatively affected if I do not have a Parent Partner assigned, or later ask for changes to my program.

I understand that if I agree to participate, the Parent Partner will share information about my family and me on a regular basis with the coordinator, Jacque Hawk, and my caseworker, \_\_\_\_\_, until my case is closed or I withdraw from the program. I understand that **I am responsible for** supplying my Parent Partner with up to date contact information and meeting face to face with my Parent Partner at least one hour each month as long as I continue using the program.

\_\_\_\_ (initial) **I agree** to have a Parent Partner, assigned to my case at this time. I hereby give my consent to the Calhoun, Pocahontas or Webster County Department of Human Services and the Parent Partner Program to share information about my family and me. I understand that this may include both verbal and written information. I understand that I can revoke this consent at anytime by submitting written notice to: **Jacque Hawk 822 Central Ave. Suite 340 Fort Dodge, IA. 50501 [jhawk@linking-families.com](mailto:jhawk@linking-families.com)**

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## RELEASE OF INFORMATION:

Identify all persons/programs/agencies that may disclose and/or receive information in addition to the DHS and Parent Partner Program. Note any information initialed below that is not authorized for release to a specific person/program/agency.

\_\_\_\_\_  
\_\_\_\_\_

By initialing next to the information listed below, I authorize the release of the specific information for the named individual(s) or myself only if it is necessary to secure or coordinate services identified in my case plan by the identified persons, agencies, or programs. Information may be released for: (Names) \_\_\_\_\_

- \_\_\_\_ A. Name, birth date, sex, race, address, and telephone number
- \_\_\_\_ B. General medical records-disability, type of services being received and name of agency providing services.
- \_\_\_\_ C. School/educational information: \_\_\_\_\_
- \_\_\_\_ D. HIV and AIDS related diagnosis and treatment
- \_\_\_\_ E. Current substance abuse treatment, recommendations and involvement, specifically: \_\_\_\_\_
- \_\_\_\_ F. Financial information necessary to establish eligibility for public assistance: \_\_\_\_\_
- \_\_\_\_ G. Participation in mandated court services: \_\_\_\_\_
- \_\_\_\_ H. Other (specify): \_\_\_\_\_

This release expires upon my written request, the closing of my participation with the parent partner program, 12 months from the date of signature or on \_\_\_\_\_.

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I have read this form or it has been read and explained to me and I understand its content. I understand that a photocopy of this signed authorization shall be accepted as an original.

Name (Print): \_\_\_\_\_

Signed: \_\_\_\_\_

Witnessed: \_\_\_\_\_

Date: \_\_\_\_\_