THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

Admission Packet

The forms in this packet need to be completed after a child has been formally accepted, and supplied to the Admissions Department at or before the scheduled admission. The admission form is for the referring county/agency to complete; the rest are customarily completed by the family, though the referring county/agency is empowered to complete them as well. Please review for completion of lines seeking information, not just signatures.

If the youth will have a case in CONNECTIONS, please assign the case to the Agency on the day of admission. The Agency is W15 and the site is 5B0 (zero).

In addition to the forms and consents included in this packet, we need **copies** of the following documents**:**

- Child's official immunization record, this can be from the school or physician
- A physical exam and a TB tine test will be administered upon admission. If either of these have been performed in the last few months, an official copy of the record may be attached.
- Child's primary insurance coverage and/or Medicaid card (front and back)
- Birth Certificate
- Social Security Card
- Court Order
- Child's current medication order

Please fax or email all documentation to our Admissions Department at admissions@gjrmail.com

Director of Admissions, Hilary Reilly, 607.844.6216, reillyh@gjrmail.com

Assistant Director of Admissions, Tiffany Sherman, 607.844.6215, shermant@gjrmail.com

Office Manager, Elizabeth Stadelman, 607.844.6392, stadelmane@gjrmail.com

Fax: 607.844.3764

CHECKLIST FOR ADMISSION CONSENT FORMS AND ACTION ITEMS

Please read carefully and make sure all required forms are signed, completed and included.

Name of Form	✓	Action Required
1. Admission Form (to be completed by responsible agency)		Fill out completely
2. Authorization for Release of Health Information (one for each provider)		Complete & Sign
3. Authorization to Provide Routine & Emergency Care		Review & Sign
4. COVID-19 Vaccine Consent Form		Complete & Sign
5. Psychotropic Prescription Medication Informed Consent Form		Complete & Sign
6. Verification of Medical Insurance Coverage		Complete & Sign
7. Medical Insurance and Assignment of Benefits Agreement		Complete & Sign
8. Child & Family Health History Form		Complete & Sign
9. HealtheConnections Consent Form		Complete & Sign
10. Receipt of Family Handbook		Review & Sign
11. Authorization for Technology Based Services Form		Review & Sign
12. Recreation Consent Form		Review & Sign
13. Physical Restraint Policy and Consent Form		Review & Sign
14. Media Release Authorization Form		Complete & Sign
15. Acknowledgement of Receipt of Notice of Privacy Practices & Personal Representative Designation		Review & Sign
George Junior Republic Union Free School District Consent Forms		
16. Consent to Evaluate		Review & Sign
17. Release of Information-WGA		Complete & Sign
18. Release of Information-Placing Agency		Complete & Sign
19. Release of Information - School		Complete & Sign
20. NYS Application for Youth Employment		Complete Part One
Outpatient Substance Use Treatment Program Consent Forms		
21. Receipt of Confidentiality Notice & Consent to Screen & Treat		Review & Sign
22. Consent to Release: Placing Agency		Complete & Sign
23. Consent to Release: MedLab		Complete & Sign
24. Consent to Release: WGA		Complete & Sign
25. Consent to Release: Parent/Guardian		Complete & Sign
26. Consent to Release-Blank (fill in)		Complete & Sign
Copies of the following documents need to be included:		
Child's official immunization record (from the school or physician)		Attach a copy
Child's primary insurance card and/or Medicaid card (front and back)		Attach a copy
Child's Birth Certificate		Attach a copy
Child's Social Security Card		Attach a copy
Court Order (if available)		Attach a copy
Child's current medication order		Attach a copy
Recent physical & TB tine test (if applicable)		Attach a copy
Youth's official school transcript (if not received already)		Attach a copy
Proof of COVID-19 vaccine (if applicable)		Attach a copy

1. ADMISSION FORM

To be completed by referring county/agency with input from family.

Child's Legal Name: (First, Middle, Last)			
CONNECTIONS Case Name:			
Date of Birth:		Social Security#:	
Most recent home address:			
With whom did youth reside at most recent home address:			

Legal Status: (Check one)					
	JD	Abuse/Neglect	PINS	CSE	Voluntary
Placing Agency:					
Expiration Date of Court Order:					
Child's Permanency Planning Goal:					
Tribal Affiliation?	Yes		No		If yes, Tribe Name:
Case Initiation Date (CID):					

Caseworker/CSE Chair:		Email:	
Phone:		Fax:	
Mailing Address:			
Emergency/After Hours Contact Information:			

Probation Officer:		Email:	
Phone:		Fax:	
Mailing Address:			

Attorney for the Child:		Email:	
Phone:		Fax:	
Mailing Address:			

Current Orders of Protection:	
Current Restitution:	

Signature:		Date:	

To be completed by the family and/or by referring county/agency.

Child's Demographic Information

Child's Name:			
Child's Preferred Name/Nickname:			
Date of Birth:		Gender:	
Race:		Ethnicity:	
Religious or Church Affiliation:			

Prior Out-of-Home Placements

Facility	Dates		Reason Code	Response to Placement
	Start	End		
1.				
2.				
3.				
4.				

Prior Outpatient Evaluations and Services

Service Provider /Agency	Dates		Reason Code	Response to Service
	Start	End		
1.				
2.				
3.				
4.				

Reason Codes			
Out-of-Home Placements			
1: Residential Treatment	2: Psychiatric Hospitalization	3: Inpatient Rehabilitation	4: Group Home
5: Shelter Care	6: Foster Care	7: Detention	
Outpatient Evaluations and Services			
1: Psychiatry	2: Therapy/Counseling	3: Day Treatment	

Educational Information

Most Recent School Attended:			
Address:			
Dates Attended:		Grade Level Achieved:	
CSE Classifications: (if applicable)			

Child's Parent/Legal Guardian (1)

Name:		Relationship:	
Address:			
Phone:		Email:	
Gender:		DOB:	
Race:		Ethnicity:	
Occupation/Financial Resource:			

Mandatory Correspondence?	Yes		No	
Visiting Resource?	Yes		No	
Medical Consent?	Yes		No	

Child's Parent/Legal Guardian (2)

Name:		Relationship:	
Address:			
Phone:		Email:	
Gender:		DOB:	
Race:		Ethnicity:	
Occupation/Financial Resource:			

Mandatory Correspondence?	Yes		No	
Visiting Resource?	Yes		No	
Medical Consent?	Yes		No	

Sibling Information

Name:		Age:		Gender:	
Location:					
Name:		Age:		Gender:	
Location:					
Name:		Age:		Gender:	
Location:					

Other Family Members or Resources

Name:				Relationship:	
Address:					
Phone:				Email:	
Contact List?	Yes		No		

Name:				Relationship:	
Address:					
Phone:				Email:	
Contact List?	Yes		No		

Emergency Contact (if Parent/Legal Guardian is not available)

Name:		Relationship:	
Address:			
Phone:			

Upcoming Appointments (court, medical)

Type	Date	Time	Location

Other Information Relevant to the Admission Process

Parent/LG Signature:		Date:	

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2. Authorization for the Release of Health Information

This authorization must be completed by the child's Medical Consenter to use/disclose protected health information in accordance with state and federal laws and regulations.

Name of Child:		DOB:	

Release Records ☐ FROM and/or ☐ TO ⟷ Release Records ☐ FROM and/or ☐ TO

The William George Agency
380 Freeville Road
Freeville, NY 13068
Phone: 607.844.6460 Fax: 607.844.4998

Name/Organization:			
Street Address:			
City/State/Zip:			
Phone:		Fax:	

Extent or nature of information to be disclosed/obtained (check all that apply)**:**

	Educational, medical, psychosocial, psychiatric, and psychological evaluations, treatment plans, summary of progress, and/or discharge summaries
	Entire Medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consultations, billing records, insurance records, medication and dosages, and records sent to you by other health care providers.
	I authorize my information to be discussed verbally.
	Other:

Purpose or Need for Information: (check all that apply):

	Service delivery and planning
	Other:

Additional Authorization to Release Sensitive Information, records containing sensitive information **will be only released** if the appropriate items are initialed by the patient/authorized representative below (initial all that apply):

	Alcohol/Drug Treatment
	Mental Health Information (except psychotherapy notes)
	HIV/AIDS/Reproductive Health Related Information

My signature below indicates that I understand the following:

(1) I may revoke this authorization in writing at any time, except to the extent The William George Agency for Children' Services has taken action in reliance to this authorization.
(2) This authorization is voluntary. My treatment, payment or eligibility for benefits will not be conditions upon my authorization of this disclosure.
(3) I have a right to a signed copy of this authorization.
(4) If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
(5) I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
(6) If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.
(7) This authorization will automatically expire **one year** after discharge from The William George Agency for Children's Services unless previously revoked by the child's legal guardian.

I have read and fully understand this authorization form. By signing below, I authorize **The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068** to obtain, use and/or disclose my protected health information consistent with the terms of this authorization, which will be effective on the date that it is signed.

Patient/Legal Guardian/Authorized Representative

Name:		Signature:		Date:	
Relationship (if not patient):					

Witness

Name:		Signature:		Date:	

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3. Authorization to Provide Routine & Emergency Care

Name of Child:		DOB:	

Medical Consent
In the admission of my child in the residential treatment program at the William George Agency for Children's Services (Agency), I **do consent** to have the licensed medical providers of the Agency provide annual physical exams, routine and emergency medical care and immunizations.

Vaccinations
Vaccinations will be ordered by the Agency's medical staff per the New York State Recommended Childhood and Adolescent Immunization Schedule which is aligned with national guidelines set by the Advisory Committee on Immunization Practices (ACIP) and recommendations by the Centers of Disease Control and Prevention (CDC). Children attending school in New York State **must** receive all required doses of vaccines on the immunization schedule, unless they have a medical exemption. The recommended vaccines include the annual Influenza and Human Papillomavirus (HPV) and if you are not in agreement with these being administered, **you must notify us in writing within 14 days.**

Routine and Emergency Medical Treatment
I understand that by my child's admission in the residential treatment program at the Agency **I consent** to the provision of routine medical care and health related services. I understand that all services for my child will be for the benefit of maintaining and improving their mental and physical health to include, but not limited to the following:

- General physical examinations, routine medical care and immunizations (as applicable)
- Psychological and/or psychiatric services
- Specialized services (such as eye, ear, nose, etc.)
- Dental check-up and services
- Over the counter medication with physician/nurse's approval to include Tylenol, Ibuprofen, Alcalak, Benadryl, Bismuth, and Phenylephrine
- Medical transportation
- Emergency room visits
- Monthly pregnancy testing for female residents

Emergency Care
Emergency medical, dental, health and hospital services or surgical care is defined as care that should be provided immediately because delay of such care places the health of the child in serious jeopardy, or in the case of a behavioral health condition places the health of such child or others in serious jeopardy. The Agency is responsible for contacting me to obtain informed consent. In the event that my child requires emergency care and I cannot be contacted at the time that such care becomes necessary, or when a physician determines that the time needed to secure my consent would endanger my child's immediate welfare, I authorize the Agency to consent to such emergency care.

In signing this consent, I am aware that The William George Agency for Children's Services staff will contact me regarding specific treatments recommended by the physicians, except for those cases where an emergency situation requires that the treatment be given immediately. In those cases, I will be notified subsequently. This authorization shall be effective until the time of discharge. I have read and understand the information regarding routine medical, dental care, immunization practice, over the counter medication's and emergency care and modalities as outlined above.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

Name of Witness:	
Signature of Witness:	
Date:	

THE WILLIAM GEORGE AGENCY

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4. COVID-19 Vaccine Consent

Name of Child:		DOB:	

COVID-19 Vaccine
While this vaccine is not mandatory, it is highly recommended for specific groups of individuals including those in congregate care.

Following the guidelines established by the CDC and the American Advisory Committee on Immunization Practices, those 12 years and older in congregate care qualify for the COVID-19 vaccination.

Do not hesitate to contact the medical clinic staff if you have any specific questions or concerns regarding this vaccine.

Check one:

	YES, I consent to my child receiving the COVID-19 Vaccination and booster.
	No, I decline my child receiving the COVID-19 Vaccination.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

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5. Psychotropic Prescription Medication Informed Consent

Name of Child:		DOB:	

	My child is not currently being prescribed psychotropic medication at time of admission.

At the time of admission to The William George Agency for Children's Services, this child has been taking the following prescription medications with my consent and understanding:

Medication Name	Dose	Time(s)	Reason Taking	Prescriber & Contact Information

I understand that while my child is receiving psychiatric treatment including, but not limited to the use of prescription medication they may be asked to submit random urine drug screens. Failure and/or refusal to submit a drug screen may result in the discontinuation of the prescribed medication. Additionally, any abuse/misuse/diversion of the prescription medication may also result in the discontinuation of the prescribed medication.

I hereby authorize the medical professionals at The William George Agency for Children's Services to continue the administration of this medication, to include making adjustments as needed. I understand that I will be notified by a member of my child's treatment team of any changes to the above medication and a new consent will be requested for any additional/new medications.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

Please note: Youth MUST arrive for admission with either a copy of their most recent medication administration record (MAR) or with their prescription bottles. Prescription medication must be in original pharmacy labeled container or it will not be accepted.

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6. Verification of Medical Insurance Coverage

Child's Name:		DOB:	
Medicaid CIN # (if applicable):			
Medicaid Managed Care Plan (if applicable):			

Primary Insurance Company (if applicable):

Policy Holder (First, Last):				DOB:	
Social Security #:				Gender:	
Address:					
Primary Phone Number:			Email:		
Relationship to Insured:			Employer:		
Insurance Company:				Phone Number:	
ID #:		Policy #:		Group #:	

Secondary Insurance Company (if applicable):

Policy Holder (First, Last):				DOB:	
Social Security #:				Gender:	
Address:					
Primary Phone Number:			Email:		
Relationship to Insured:			Employer:		
Insurance Company:				Phone Number:	
ID #:		Policy #:		Group #:	

Please provide a photocopy of both sides of the Medicaid and/or insurance card(s).

Parent/LG Signature:		Date:	

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7. Medical Insurance and Assignment of Benefits Agreement

Name of Child:		DOB:	

I authorize The William George Agency for Children's Services to release records and/or treatment information to insurance and/or Medicaid carriers and their agents concerning my presence in treatment, diagnosis, treatment plan, progress, and prognosis, for the purpose of clarifying my condition and justifying payment by the carrier.

It is my responsibility to inform The William George Agency for Children's Services of any changes in my insurance coverage.

For children placed by the Committee on Special Education (CSE) only: If my child is insured under Medicaid and Managed Care (MMC), I am responsible to recertify in a timely manner to avoid any insurance lapse.

I understand that my treatment records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I understand that I may revoke this consent at any time by notifying the agency in writing, except to the extent that action has been taken in reliance on my consent.

I understand this consent will automatically expire upon discharge from the Agency and when all billing claims are filed and processed.

Rendered Services-Assignment of Benefits

I assign all payments for services rendered to my child directly to The William George Agency for Children's Services.

I understand that I am responsible for sending all related correspondence (i.e., explanation of benefits) to the Agency.

In the event that the Agency submits a claim on my child's behalf, and the reimbursement check comes directly to me, I will sign it and endorse the back to read **"pay to the order of The William George Agency"** and mail the check and the related correspondence (including explanation of benefits) within five (5) business days to the following address:

The William George Agency
380 Freeville Road
Freeville, NY 13068

Primary Policy Holder Signature:	
Date:	

Secondary Policy Holder Signature:	
Date:	

Medicaid Only Sign Here:

Parent/LG Signature:		Date:	

THE WILLIAM GEORGE AGENCY

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8. Child & Family Health History Form

Name of Child:		DOB:	

Allergies

Does your child have any allergies:		No		Yes – please list below

Allergy	Adverse Reaction

Child's Medical History (if yes, please indicate age and explain)

Condition	Yes	No	Age	Explain
Convulsions/Seizures				
Meningitis				
Measles				
Rubella				
Chicken Pox				
Mumps				
Pneumonia				
Whooping Cough				
Scarlett Fever				
Poliomyelitis				
Rheumatic Fever				
Asthma, Hay Fever, Hives				
Chronic Ear Infections				
Stomach or Intestinal Disorders				
Heart Disorders				
Diabetes				
Sinus Trouble/Tonsillitis				
Frequent Respiratory Infections				
Head Trauma				
Frequent/Severe Headaches				
Liver Disease or Jaundice				
Kidney or Bladder Disease or Enuresis				
Bone or Joint Disease/Deformity				
Chronic Illnesses				
Eating Disorders				
Sleep Disorders				
Other Medical Problems				

Surgeries and Hospitalizations

Procedure/Problem	Age	Explain

Primary Care Physician

Name:		Phone Number:	
Mailing Address:			

Dentist

Name:		Phone Number:	
Mailing Address:			

Orthodontist

Name:		Phone Number:	
Mailing Address:			

Specialty Doctor

Name:		Phone Number:	
Mailing Address:			

Upcoming Medical Appointments

Does your child have any upcoming medical appointments?		No		Yes – please list below

Date	Time	Doctor	Purpose

Family Medical History

If yes, please list which immediate family member(s) (biological grandparents, parent, siblings) has the condition and any details you feel necessary.

Condition	Yes	No	Details
Asthma/Hay Fever			
Cancer			
Stroke/Heart Attack			
Kidney Disease			
Blood Disease			
Diabetes			
Tuberculosis			
High Blood Pressure			
Mental Illness			
Alcohol/Substance Use Disorder			
Sudden Death			

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

THE WILLIAM GEORGE AGENCY

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

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10. Receipt of Family Handbook

Name of Child:		DOB:	

In the "Family Handbook" there are some statements, policies, and procedures for your information. We appreciate your support of these guidelines to promote the safety, well-being and personal growth of your child.

- List of What to Bring and Prohibited Items
- Notice of Privacy Practices
- Psychiatric Care and Psychotropic Medication Procedures
- Medical Insurance and Payment for Rendered Services Agreement
- George Junior Republic Union Free School District-Prior Written Notice Proposed Reevaluation
- George Junior Republic Union Free School District-Pesticide Notification
- Adolescent Chemical Dependency Program Notice of Confidentiality

I have received the documents listed above and understand that I am responsible for their contents. I further understand that the William George Agency is not responsible to replace personal items brought to campus. In addition, I understand that if I am found to be in the possession of prohibited items they will be mailed home first and if they return to campus, held until discharge.

Parent/Guardian Signature:		Date:	

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11. Authorization to Provide Technology Based Services

Name of Child:		DOB:	

The William George Agency for Children's Services Inc. ("Agency"), located at 380 Freeville Rd., Freeville, NY 13068 provides and maintains multiple forms of electronic communication to include; video platforms, messaging agents, internal and external electronic mail (e-mail), text messaging, telephone, voice mail, internet, and software to communicate throughout the treatment process. The forms of video communication systems used by the Agency are; doxy.me, Web Ex, and Zoom all of which are HIPPA compliant.

In the admission of my child to The William George Agency, I understand that my child will receive individual face to face counseling services provided by clinical providers. These providers may include Behavioral Health Clinicians, Family Services Coordinators, Psychiatric Nurse Practitioner, Registered Nurses, Medical Physicians, Substance Abuse Counselors and/or Clinical Supervisors. However, in the event a face to face is unable to occur, these providers may facilitate virtual meetings for the purposes of but not limited to counseling sessions, legal proceedings, and referral resources by means of the platforms identified above.

Benefits

Technology based services are provided to offer the following anticipated benefits:

- Increased access to care (i.e., when access to care is limited due to disabilities, transportation issues, weather, illness, or emergencies)
- Effective care, which is supported by a growing body of literature
- Convenience regarding scheduling, travel time, etc.
- Cost savings (i.e., reduce travel costs, time off work/school)
- Reduced perceived stigma (due to not being in an office setting)

Risks

Technology based services are conducted and documented in a confidential manner according to applicable laws in similar ways as in-person services. There are, however, additional risks including:

- Sessions could be disrupted, delayed, or communications distorted due to technical failures.
- Technology based services involves alternative forms of communication that may reduce visual and auditory cues and increase the likelihood of misunderstanding one another.
- In rare cases security protocols could fail and your confidential information could be accessed by unauthorized persons.

Client Rights

- You have the right to withhold or withdraw my consent to the use of technology based services during the course of my care at any time. I understand that my withdraw of consent will not affect any future care or treatment.
- I understand that the rules and regulations that apply to the provision of healthcare services in the State of New York also apply to technology based services.
- I understand that my provider has the right to withhold or withdraw consent for the use of technology based services during the course of my care at any time.

Policies and Procedures
The Agency works to reduce the associated risks by phone and video conferencing services by the implementation of the following policies and procedures:

- You may only engage in sessions when you are physical in New York State. Your provider will confirm your location at each session.
- You and your provider will engage in sessions only from a private location where you will not be overheard or interrupted.
- You will not record any sessions; nor will your provider record your session without your written consent.
- You will provide contact information for at least one emergency contact in your location whom your provider may contact if you are in crisis and your provider is unable to reach you.
- Your provider will offer education on how to utilize the technology platforms and necessary hyperlinks prior to the scheduled appoint in which they will need to be used.

Should there be technical problems with technology based services, your provider will call you back, and/or log out of video conferencing and back in within five minutes. Make sure your provider has a correct phone number at which you can be reached, and have your phone with you at your scheduled time. If you are unable to connect, or get disconnected, please try to connect again and if problems continue call the office or send a message to your provider via the email provided. If we believe you are in crisis and we are unable to contact you, we may call your emergency contact or local emergency service providers.

Please be aware that electronic communication may not be secure. If you have concerns about phone and/or video conferencing sessions, please discuss these with your provider.

Emergencies
The Agency cannot provide 24-hour emergency management, particularly to those using services at a distance. If you are experiencing an emergency, including a mental health crisis, you agree to make use of the following 24/7 resources:

- Call the National Suicide Prevention Hotline: 1-800-273-8255
- Call 911, or go to the nearest emergency room.

Professional Records
I understand that conversations that occur during technology based interactions will be documented as part of the case record in the progress notes for treatment planning purposes. The information is maintained in the New York State regulated documentation system, "Connections" and in the Agency's Electronic Health Record (EHR) known as Welligent.

Mandated Reporters
I understand that the privacy laws that protect my child's confidentiality also applies when technology services are in use and exceptions do apply in the instance there is a need to report mandatory abuse of a child or adult, or if there is risk of danger to self or others.

Name of Parent/Legal Guardian:			
Signature of Parent/Legal Guardian:		Date:	

Name of Witness:			
Signature of Witness:		Date:	

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

12. Therapeutic Recreational Activities Consent

Name of Child:		DOB:	

It is the mission of The William George Agency for Children's Services ("Agency") and its staff to provide motivated, supportive, and therapeutic recreational programming for the clients of the Agency. This mission is accomplished by providing a multi-faceted approach to recreation and leisure programming that includes necessary elements for appropriate sportsmanship, team work, fitness, nutrition and general understanding of the importance of overall health and well-being.

The William George Agency Recreation and Equine staff are trained and experienced in supervising and teaching children engaged in these activities. The William George Agency Medical Clinic personnel, together with our Recreation and Equine staff, will be evaluating my child's physical health and ability to participate in recreational activity. Nonetheless, I am aware of the risks inherently involved in such activities, including falls, collisions, hazards within the natural environment.

I hereby consent that I am aware of the therapeutic recreational activities provided as part of the total learning experience at The William George Agency, to include but not limited to:

- Horseback Riding
- Bowling
- In-line Skating
- Ping Pong
- Arts & Crafts
- Floor Hockey
- Flag Football
- Basketball
- Swimming
- Softball
- Soccer
- Volleyball
- Fitness Training
- Ultimate Frisbee
- Hiking
- Fishing
- Biking
- Canoeing/Kayaking
- Theme Park Trips
- Rafting
- Rock Climbing/Tower
- Yoga/Pilates
- Snowboard/skiing
- Sledding
- High Ropes
- Challenge Course
- Canine-Assisted Interventions Program

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

13. Physical Restraint Policy

Name of Child:		DOB:	

Acute physical behaviors occur in children because they are temporarily overwhelmed by very strong impulses, lack of adequate self-control, or on some level, find their behaviors acceptable. The therapeutic program of the Agency has several components designed to help the residents gain increased and acceptable controls over their behavior and help prevent situations that may lead to the use of a restraint. Despite this, some of the children whom we work with periodically present with aggressive, out of control behaviors which require physical restraint by staff in order to ensure their safety and the safety of others.

In order to fully protect children placed in campus programs to themselves and/or others, it may be necessary for The William George Agency for Children's Services staff to physically restrain a child in certain situations. Agency staff carefully adhere to the regulations and instructions related to physical restraint methods issued by the NYS Office of Children and Family Service (OCFS). Physical restraint is only used after all other possible options have been exhausted. A nurse is immediately called to the location of the emergency situation to evaluate the youth and to ensure the safety and physical well-being of the youth.

I have read and acknowledge the use of physical restraint by this Agency for the safety of my child.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

Name of Witness:	
Signature of Witness:	
Date:	

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

14. Media Release Authorization Form

Name of Child:		DOB:	

The William George Agency for Children's Services (Agency) participates in public relations activities and develops promotional materials that help us to tell our story to the community. The story and/or photographs of a youth is a powerful way to explain how the Agency helps and empowers youth to reach their potential. At times, certain activities, photos, and/or written/verbal statements by youth may be considered for the Agency's website, promotional materials (printed or video) and fundraising initiatives. Youth may participate in these opportunities if their parent/guardian has provided written consent below. The youth always has the choice whether to participate or not. We adhere to the confidentiality of youth and as such, first names only are used in publication.

Check one:

	I give the Agency authorization to record the image/or voice of the child named above, and I grant the Agency all rights to use these sound, still, or moving images in any medium for educational, promotional, advertising, or other purposes that support the mission of the Agency. I understand that I may revoke or withdraw this permission at any time to prohibit future use and to do so I will send written notice to The William George Agency at 380 Freeville Road, Freeville, NY 13068.
	I decline to permit my child's photograph to be taken.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

15. Acknowledgement of Receipt of Notice of Privacy Practices & Personal Representative Designation

Name of Child:		DOB:	

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of the William George Agency's Notice of Privacy Practice which is located in the Parent/Guardian Information Packet. I understand the content of the Privacy Notice and I am aware of whom to contact with questions regarding my PHI and authorization.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

Personal Representative Designation

In the event that there is an allegation of possible child abuse at this agency, NYS Justice Center for the Protection of People with Special Needs rules require us to allow a personal representative of the child to be present during the investigation. Personal representatives may be parent, guardian, or other persons legally responsible for the child.

Please indicate below who the personal representative will be if needed:

Name:	
Relationship to Child:	
Phone Number:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

ADMISSIONS DEPARTMENT
16. Consent to Evaluate

Name of Child:		DOB:	

All children being admitted to The William George Agency for Children's Services attend the George Junior Republic Union Free School District. Upon their admission, each child is evaluated and will be reviewed by either an Educational Planning Committee or the Committee on Special Education. This ensures appropriate educational programming. Student who are already classified and receive Special Educational Services or that already have an Educational Plan may also need reevaluation or a Functional Behavioral Assessment. Parents are welcome to call the school office with questions or concerns about the evaluation process, the categories of special education services, or the school curriculum.

I have received Prior Written Notice for evaluation or re-evaluation which was provided to me in the Parent Information Packet. I hereby grant permission for my child to be evaluated as needed or as appropriate.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

ADMISSIONS DEPARTMENT
17. Authorization to Release Information (WGA)

Name of Child:		DOB:	

The Family Educational Rights and Privacy Act (FERPA) protects student's confidentiality by placing certain restrictions on the disclosure of information contained in a student's education records. By signing this form, you agree that permission is hereby given to The George Junior Republic Union Free School District to receive and/or release information to and/or from:

The William George Agency for Children's Services Inc.
Freeville, NY 13068

The nature of information to be disclosed/obtained is:

Full Educational Record to include transcripts, report cards, standardizes testing scores, attendance records, IEP and other pertinent documentation, psychological reports, health record information to include immunizations

For the purpose or need of the use or disclosure:

To aid in the admission process, for the coordination and continuation of services and for periodic reporting as required by placement agency.

This authorization will automatically expire at the time of the child's discharge from The William George Agency for Children's Services unless previously revoked by the child's legal guardian.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

ADMISSIONS DEPARTMENT

18. Authorization to Release Information (Placing Agency)

Name of Child:		DOB:	

The Family Educational Rights and Privacy Act (FERPA) protects student's confidentiality by placing certain restrictions on the disclosure of information contained in a student's education records. By signing this form, you agree that permission is hereby given to The George Junior Republic Union Free School District to receive and/or release information to and/or from:

County/OCFS/CSE:

The nature of information to be disclosed/obtained is:

Full Educational Record to include transcripts, report cards, standardizes testing scores, attendance records, IEP and other pertinent documentation, psychological reports, health record information to include immunizations

For the purpose or need of the use or disclosure:

To aid in the admission process, for the coordination and continuation of services and for periodic reporting as required by placement agency.

This authorization will automatically expire at the time of the child's discharge from The William George Agency for Children's Services unless previously revoked by the child's legal guardian.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

ADMISSIONS DEPARTMENT
19. Authorization to Release Information (School)

Name of Child:		DOB:	

The Family Educational Rights and Privacy Act (FERPA) protects student's confidentiality by placing certain restrictions on the disclosure of information contained in a student's education records. By signing this form, you agree that permission is hereby given to The George Junior Republic Union Free School District to receive and/or release information to and/or from:

Current or most recent School District:			
Address:			
Phone Number:		Grade Last Attended:	

The nature of information to be disclosed/obtained is:

	Transcripts	
	Report Card(s)	
	Standardized Test Scores	
	Individualized Education Plan (IEP) and other pertinent documentation	
	Health Record Information & Immunizations	
	Psychological Reports	
	Withdrawal Grades	
	Other:	

For the purpose or need of the use or disclosure:

To aid in the admission process, for the coordination and continuation of services and for periodic reporting as required by placement agency.

This authorization will automatically expire at the time of the child's discharge from The William George Agency for Children's Services unless previously revoked by the child's legal guardian.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Date:	

AT-17
Rev. 3/20

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
ALBANY, NY 12234

APPLICATION FOR EMPLOYMENT CERTIFICATE

See reverse side of this form for information concerning employment of minors.

Applicant must appear in person before the certifying official.

THIS APPLICATION DOES NOT AUTHORIZE EMPLOYMENT

PART I – Parental Consent – (To be completed by applicant and parent or guardian)

Parent or guardian must appear at the school or issuing center to sign the application for the first certificate for full-time employment, unless the minor is a graduate of a four-year high school and presents evidence thereof. For all other certificates, the parent or guardian must sign the application, but need not appear in person to do so.

Date……

I, …… Age ……..…
[Applicant]

Home Address ……....., apply for a certificate as checked below
[Full Home Address including Zip Code]

☐ Nonfactory Employment Certificate – Valid for lawful employment of a minor 14 or 15 years of age enrolled in day school when attendance is not required.

☐ Student General Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age enrolled in day school when attendance is not required

☐ Full-Time Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age who is not attending day school

I hereby consent to the required examination and employment certification as indicated above.

……
[Signature of Parent or Guardian]

PART II – Evidence of Age – (To be completed by issuing official only)

……. – Check evidence of age accepted – Document # (if any) ……..
[Date of Birth]

☐ Birth Certificate ☐ State Issued Photo [ ] I.D Driver's License ☐ Schooling Record ☐ Other [Specify].....

PART III – Certificate of Physical Fitness

Applicant shall present documentation of physical exam from a school or private physician, physician's assistant or nurse practitioner authorized to practice within New York State.* Said examination must have been given within 12 months prior to issuance of the employment certificate. Date of physical exam on file with school …… If physical exam is over 12 months, provide student with Certificate of Physical Fitness to be completed by school medical director or private health care provider.

If the physical exam or Certificate of Physical Fitness is limited with regard to allowed work/activity, the issuing official shall issue a Limited Employment Certificate, which will be valid for a period not to exceed 6 months, unless the limitation noted by the physician is permanent, in which case, the certificate will remain valid until the minor changes jobs. Enter the limitation on the employment certificate.

THE PHYSICIAN'S CERTIFICATION SHOULD BE RETURNED TO THE APPLICANT.

****Education Law Article 131, Section 6526* lists exempted physicians authorized to practice in the state without a NYS license. *Education Law Article 139 section 6908(f) lists exempted persons authorized to practice nursing (inclusive of nurse practitioners) in the state without a NYS license.***

PART IV – Pledge of Employment – (To be completed by prospective employer)

Part IV must be completed only for: (a) a minor with a medical limitation; and (b) for a minor 16 years of age or legally able to withdraw from school, according to Section 3205 of the Education Law, and must show proof of having a job.

The undersigned will employ …… residing at ……
[Applicant]

as …… at ……
[Description of Applicant's Work] **[Job Location]**

for …… days per week ……. hours per day, between …… a.m. and ……..…… p.m.

Starting date ……..

…… ……... ☐ Factory ☐ Nonfactory
[Name of Firm] **[Address of Firm]**

…… ……..
[Telephone Number] **[Signature of Employer]**

PART V – Schooling Record – (To be completed by school official)

Part V must be completed only for a minor 16 years of age who is leaving school and resides in a district (New York City and Buffalo) which require a minor 16 years of age to attend school, according to Section 3205 of the Education Law.

I certify that the records of …… ……
[Name of School] **[Address]**

Show that …….. whose date of birth is ……
[Name of Applicant]

Is in grade…… ……
[Signature of Principal or Designee]

PART VI – Employment Certification – (To be completed by issuing official only)

Certificate Number ……..... Date Issued……

…… …….. ……
[School or Issuing Center] **[Address]** **[Signature of Issuing Officer]**

GENERAL INFORMATION

An employment Certificate (Student Nonfactory, Student General, or Full Time) may be used for an unlimited number of successive job placements in lawful employment permitted by the particular type of certificate.

A Nonfactory Employment Certificate is valid for 2 years from the date of issuance or until the student turns 16 years old, with the exception of a Limited Employment Certificate. A Limited Employment Certificate is valid for a maximum of 6 months unless the limitation noted by the physician is permanent, then the certificate will remain valid until the minor changes job. It may be accepted only by the employer indicated on the certificate.

A new Certificate of Physical Fitness is required when applying for a different type of employment certificate, if more than 12 months have elapsed since the previous physical for employment.

An employer shall retain the certificate on file for the duration of the minor's employment. Upon termination of employment, or expiration of the employment certificate's period of validity, the certificate shall be returned to the minor. A certificate may be revoked by school district authorities for cause.

A minor employed as a Newspaper Carrier, Street Trades Worker, Farmworker, or Child Model, must obtain the Special Occupational Permit required.

A minor 14 years of age and over may be employed as a caddy, babysitter, or in casual employment consisting of yard work and household chores when not required to attend school. Employment certification for such employment is not mandatory.

An employer of a minor in an occupation which does not require employment certification should request a Certificate of Age.

PROHIBITED EMPLOYMENT

Minors 14 and 15 years may not be employed in, or in connection with a factory (except in delivery and clerical employment in an enclosed office thereof), or in certain hazardous occupations such as: construction work; helper on a motor vehicle; operation of washing, grinding, cutting, slicing, pressing or mixing machinery in any establishment; painting or exterior cleaning in connection with the maintenance of a building or structure; and others listed in Section 133 of the New York State Labor Law.

Minors 16 and 17 years of age may not be employed in certain hazardous occupations such as: construction worker; helper on a motor vehicle, the operation of various kinds of power-driver machinery; and others listed in Section 133 of the New York State Labor Law.

HOURS OF EMPLOYMENT

Minors may not be employed during the hours they are required to attend school.

Minors 14 and 15 years of age may not be employed in any occupation (except farmwork and delivering, or selling and delivering newspapers):

When school is in session:

- more than 3 hours on any school day, more than 8 hours on a nonschool day, more than 6 days in any week, for a maximum of 18 hours per week, or a maximum of 23 hours per week if enrolled in a supervised work study program approved by the Commissioner.
- after 7 p.m. or before 7 a.m.

When school is not in session:

- more than 8 hours on any day, 6 days in any week, for a maximum of 40 hours per week.
- after 9 p.m. or before 7 a.m.

This certificate is not valid for work associated with newspaper carrier, agriculture or modeling.

Minors 16 and 17 years of age may not be employed: --

When school is in session:

- more than 4 hours on days preceding school days; more than 8 hours on days not preceding school days (Friday, Saturday, Sunday and holidays), 6 days in any week, for a maximum of 28 hours per week.
- between 10 p.m. and 12 midnight on days followed by a school day without written consent of parent of guardian and a certificate of satisfactory academic standing from the minor's school (to be validated at the end of each marking period).
- between 10 p.m. and 12 midnight on days not followed by a school day without written consent of parent or guardian.

When school is not in session:

- more than 8 hours on any day, 6 days in any week, for a maximum of 48 hours per week.

EDUCATION LAW, SECTION 3233

"Any person who knowingly makes a false statement in or in relation to any application made for an employment certificate or permit as to any matter by this chapter to appear in any affidavit, record, transcript, certificate or permit therein provided for, is guilty of a misdemeanor."

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

21. Receipt of Confidentiality Notice & Consent to Screen and Treat

Name of Child:		DOB:	

Acknowledgement of Receipt of Confidentiality Notice

I acknowledge that I received a copy of the Van Clef Adolescent Outpatient Chemical Dependency Program's Notice of Confidentiality which is located in the Parent/Guardian Information Packet. I understand the content of the Confidentiality Notice and I am aware of whom to contact with questions regarding my PHI and authorization.

Consent for Substance Abuse Screening/Treatment of Minors

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program at The William George Agency for Children's Services, Inc. to render professional to services to my child.

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

22. Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient

Name of Child:		DOB:	

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program for The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068 to obtain or disclose information as set forth in this form.

Individuals or entities to whom or from whom the information may be obtained or disclosed:

Name of Placing Agency:	
Address:	
Phone Number:	

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

	Presence in treatment, prognosis, brief description of progress or occurrence of relapse	
	Medical history and physical, intake sheet, psychosocial assessment, treatment plan, aftercare plan and discharge summary	
	Other:	

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:

	To provide ongoing treatment and care coordination of service with other appropriate staff members
	To obtain insurance, employment or government benefits
	To enable judges, attorneys, probation/parole officers, caseworkers to support treatment goals or make legal decisions on my behalf

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: This consent will expire when treatment is completed and all billing claims are filed and processed.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Name of Patient:	
Signature of Patient:	
Witness Signature:	
Date:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

WGA use only:
Instructions: Give a copy of this form to the patient. Prepare one copy for the patient's case record. If this form is used for billing purposes, prepare an additional copy for the Accounting Department. If this form is sent to another agency with a request for information, prepare an additional copy for the patient's case record.

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

23. Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient

Name of Child:		DOB:	

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program for The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068 to obtain or disclose information as set forth in this form.

Individuals or entities to whom or from whom the information may be obtained or disclosed:
Medlab Incorporated

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

	Presence in treatment, prognosis, brief description of progress or occurrence of relapse	
	Medical history and physical, intake sheet, psychosocial assessment, treatment plan, aftercare plan and discharge summary	
	Other:	

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:

	To provide ongoing treatment and care coordination of service with other appropriate staff members
	To obtain insurance, employment or government benefits
	To enable judges, attorneys, probation/parole officers, caseworkers to support treatment goals or make legal decisions on my behalf

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: This consent will expire when treatment is completed and all billing claims are filed and processed.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Name of Patient:	
Signature of Patient:	
Witness Signature:	
Date:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

WGA use only:
Instructions: Give a copy of this form to the patient. Prepare one copy for the patient's case record. If this form is used for billing purposes, prepare an additional copy for the Accounting Department. If this form is sent to another agency with a request for information, prepare an additional copy for the patient's case record.

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

24. Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient

Name of Child:		DOB:	

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program for The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068 to obtain or disclose information as set forth in this form.

Individuals or entities to whom or from whom the information may be obtained or disclosed:
The William George Agency for Children's Services
380 Freeville Road
Freeville, NY 13068

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

	Presence in treatment, prognosis, brief description of progress or occurrence of relapse	
	Medical history and physical, intake sheet, psychosocial assessment, treatment plan, aftercare plan and discharge summary	
	Other:	

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:

	To provide ongoing treatment and care coordination of service with other appropriate staff members
	To obtain insurance, employment or government benefits
	To enable judges, attorneys, probation/parole officers, caseworkers to support treatment goals or make legal decisions on my behalf

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: This consent will expire when treatment is completed and all billing claims are filed and processed.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Name of Patient:	
Signature of Patient:	
Witness Signature:	
Date:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

WGA use only:
Instructions: Give a copy of this form to the patient. Prepare one copy for the patient's case record. If this form is used for billing purposes, prepare an additional copy for the Accounting Department. If this form is sent to another agency with a request for information, prepare an additional copy for the patient's case record.

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

25. Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient

Name of Child:		DOB:	

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program for The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068 to obtain or disclose information as set forth in this form.

Individuals or entities to whom or from whom the information may be obtained or disclosed:

Name of Parent/Legal Guardian (1):	
Name of Parent/Legal Guardian (2):	

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

	Presence in treatment, prognosis, brief description of progress or occurrence of relapse	
	Medical history and physical, intake sheet, psychosocial assessment, treatment plan, aftercare plan and discharge summary	
	Other:	

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:

	To coordinate treatment efforts with my family/concerned persons
	Any Pertinent Information

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: This consent will expire when treatment is completed and all billing claims are filed and processed.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Name of Patient:	
Signature of Patient:	
Witness Signature:	
Date:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

WGA use only:
Instructions: Give a copy of this form to the patient. Prepare one copy for the patient's case record. If this form is used for billing purposes, prepare an additional copy for the Accounting Department. If this form is sent to another agency with a request for information, prepare an additional copy for the patient's case record.

THE WILLIAM GEORGE AGENCY

ADMISSIONS DEPARTMENT

26. Consent to Release of Information Concerning Alcoholism/Drug Abuse Patient

Name of Child:		DOB:	

I hereby authorize the Van Clef Adolescent Outpatient Chemical Dependency Program for The William George Agency for Children's Services located at 380 Freeville Road, Freeville, NY 13068 to obtain or disclose information as set forth in this form.

Individuals or entities to whom or from whom the information may be obtained or disclosed:

EXTENT OR NATURE OF INFORMATION TO BE DISCLOSED/RELEASED

	Presence in treatment, prognosis, brief description of progress or occurrence of relapse	
	Medical history and physical, intake sheet, psychosocial assessment, treatment plan, aftercare plan and discharge summary	
	Other:	

PURPOSE OR NEED FOR DISCLOSURE/RELEASE:

	To provide ongoing treatment and care coordination of service with other appropriate staff members
	To obtain insurance, employment or government benefits
	To enable judges, attorneys, probation/parole officers, caseworkers to support treatment goals or make legal decisions on my behalf

I, the undersigned, have read the above and authorized the staff of the disclosing/releasing facility named to disclosure/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure/release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. Time period, event or condition replacing period specified above: This consent will expire when treatment is completed and all billing claims are filed and processed.

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form, as recognized by my signature below.

Name of Patient:	
Signature of Patient:	
Witness Signature:	
Date:	

Name of Parent/Legal Guardian:	
Signature of Parent/Legal Guardian:	
Witness Signature:	
Date:	

WGA use only:
Instructions: Give a copy of this form to the patient. Prepare one copy for the patient's case record. If this form is used for billing purposes, prepare an additional copy for the Accounting Department. If this form is sent to another agency with a request for information, prepare an additional copy for the patient's case record.