Parent/Guardian Consent Form for Group

Student Name:_____ Group Name:_____

I,_____give my consent for_____, The Holcomb
Parent/Guardian Name Holcomb Liaison

Behavioral Health Systems Liaison to meet with my child regarding an educational support group that my son/daughter has expressed interest in.

1. I understand that this educational support group consists of several face to face, semi-structured meetings designed to enhance understanding and skill development as it relates to an identified subject matter.
2. I understand that my child's involvement with the Student Assistance Program and Holcomb Behavioral Health Systems is voluntary unless my child has violated school district policy in which case participation in this group may be mandatory. I will reference my child's school district policy for more information.
3. I understand that the information obtained from this group is protected by both State and Federal confidentiality rules (71 P.S. 1690, 4 PA Code 255.5, and 42 CFR, part 2). The state law maintains that all information shall remain confidential and may be disclosed only with the person's consent and only to specified recipients as identified in 71 P.S. 1690 and 4 PA Code 255. The Federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains 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. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. Information is also protected by The Health Insurance Portability and Accountability Act (HIPPA 45 CFR part 162) which refers to requirements in other applicable laws and indicates that signed consent is always necessary to release information from this group.
4. I understand that, with my child's signed consent, recommendations from this group will be shared with me and the Student Assistance Team, as necessary.
5. I understand that information will be shared without consent, if my child expresses the intention of harming him/herself or others, or if there is suspicion of child abuse, as defined and mandated by law.
6. I understand that periodically Holcomb Behavioral Health System's Prevention Manager may be observing the educational group in which my child participates to ensure the highest level of service is being provided.
7. I understand that Holcomb Behavioral Health Systems will request feedback from my child regarding their perspective on the effectiveness of the service offered to them.
8. I understand that I may revoke this consent verbally or in writing at any time by notifying Holcomb Behavioral Health Systems, except to the extent that action has been taken in reliance on my consent. I understand that this consent expires one (1) year from the date of execution.
9. I understand that if I have a complaint (concern regarding any component of service delivery) or a grievance (request for reconsideration of a decision made regarding my child), I can contact the Prevention Manager of Holcomb Behavioral Health Systems at (610) 363-1488 to discuss my concerns.

_____ _____
Parent/Guardian Signature Date

_____
Phone Number