

Participant Information

- **Name:** _____
- **Date of Birth:** _____
- **Address:** _____
- **Phone Number:** _____

Purpose of This Authorization

I understand that the SWORPS Access and Visitation Program must keep my personal and program information private.

By signing this form, I give permission for the Access and Visitation Program to **share and/or receive information** about me that is related to my participation in the program.

This information will only be used to:

- Help me receive services and supports, and
- Improve the quality and coordination of the program.

Only the **minimum information necessary** will be shared.

Who May Receive or Share My Information

Please check all that apply and list contact name(s) and/or agencies:

- Custodial parent or Legal Guardian: _____
- Child's Primary Caregiver: _____
- Attorney(s) related to my case: _____
- Community Agency: _____
- Child Support Services/Courts: _____

Other (please list): _____

Types of Information That May Be Shared

Information shared may include:

- Participation status in the program
- Appointment scheduling and attendance
- Service coordination information
- Progress related to program goals

No medical, mental health treatment, or substance use treatment records will be shared unless required by law or specifically authorized by me in writing.

Quality Improvement Acknowledgement

I understand that Access and Visitation staff may occasionally observe appointments or review services to improve program quality. This may include staff members who are not my direct service providers. My services will not be affected if I choose not to sign this form.

My Rights

- I may refuse to sign this authorization. Refusing will not affect my ability to receive services.
- I may cancel (revoke) this authorization at any time by providing a written request to the program.
- I understand that once information is shared, it may no longer be protected under HIPAA, depending on the recipient.

Length of Authorization

This authorization is valid for **one (1) year** from the date I sign below, unless I cancel it earlier in writing.

Participant Consent and Signature

I have read this form (or had it read to me). I understand it, and my questions have been answered. By signing below, I agree to the sharing and/or receiving of information as described above.

Participant Signature:

Participant Printed Name:

Date:
