



Volunteer Emergency Families for Children (VEFC)
**Permission to Shelter and
 Authorization to Release Information**

*To be signed when child is NOT in custody of an agency
 Copy to be sent to the VEFC Richmond Office*

This agreement, made this _____ day of _____ by and between _____, parent(s)/guardian _____ (*child/youth*) and _____ (*referral agency*). I/We, parent(s)/guardian(s) of _____ (*child/youth*) request temporary placement of him/her by _____ (*agency*) with an approved Volunteer Emergency Families for Children (VEFC) host family for a temporary time not to exceed 15 days unless an extension, not to exceed a total of 21 days, is approved by a _____ (*agency*) representative, the parent(s)/guardian(s), the VEFC host family and the VEFC professional staff. During this time I/we will work with the _____ (*agency*) to strengthen our family and parental functioning for my/our child. I/we understand that upon my/our request, my/our child shall be returned to me/us at any time during this period. During this time I/we remain the legal custodian of this child and I/we am/are legally responsible for him/her and will be financially responsible for medical or dental care for my/our child should it be needed. I authorize _____ (*agency*) or the VEFC Host family to obtain emergency medical or dental care should it be needed.

I/We agree to indemnify, reimburse, hold and save harmless _____ (*agency*), VEFC, its agents and employees, and/or the VEFC Host family, for any and all injuries or accidents to my/our child or caused by my/our child against all costs, damages, expenses, or judgment including the cost of the defense thereof by _____ (*agency*), VEFC, their agents or employees, and/or the VEFC Host family, while he/she is in the care of _____ (*agency*) or the VEFC family.

I/We authorize employees and/or agents of the placing agency and/or VEFC to provide transportation for my child.

I, authorized representative of _____ (*agency*) agree to accept the child/youth for placement and to supervise his/her placement with a VEFC Host family during which time I will work with the parent(s)/guardian(s) to strengthen family and parental functioning for the child/youth. Should contact or visitation between the child/youth in placement and his/her family be necessary, I will initiate and coordinate all contact and visitation between child/youth and his/her family(s)/guardian(s). Should emergency medical treatment be required, I will notify the parent(s)/guardian(s) as soon as possible.

I agree that my/our child may be removed from the VEFC family upon the request of _____ (*agency*), the VEFC Host family, or the VEFC professional staff.

Any information regarding a VEFC family will remain confidential and cannot be released under any condition without written permission by the VEFC family and the VEFC organization now or in the future.

Youth requesting counseling: Yes No Family requesting counseling: Yes No

To the parents/guardians:

While your child/youth is in a VEFC host home your responsibilities during the time period of this placement are:

- 1) Provide for all clothing, toiletry, and financial needs of your child/youth.
- 2) Provide for any medical/surgical needs that may arise for your child/youth.

I give my permission for my child/youth to participate in all approved activities in which the VEFC host family parents may be involved in (i.e. Church, family outings, etc.)

Parent/Guardian

Agency Representative

For children 10 and older, please complete information on page 2

One Copy - FAX or Mail to VEFC Central Office One Copy for Agency One Copy: Host Family One Copy: Parent/Guardian

Permission to Shelter and Authorization to Release Information (Continued)

In compliance with Federal Regulations (42.U.S.C.4582 and 21 U.S.C.1175) _____ (agency) and all individuals/agencies involved with the treatment and/or after care plan of said youth is/are hereby authorized to release to VEFC all records and reports regarding my child, _____, to include, but not limited to: medical information, psychological/psychiatric reports, social summaries, discharge summary, and any other program forms needed. This consent can be cancelled in writing by me at anytime except to the extent information has already been released. This consent shall be valid only for that period reasonable necessary to accomplish the above stated purpose(s).

Youth's Name: _____

I, _____ parent/guardian of: _____

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form for

(Full printed name of consenting person or persons)

(Full Printed Name of Client)

(Client's Address)

(Client's Birth date)(Client's Social Security No. - Optional)

My relationship to the client is: Self Parent Power of Attorney Guardian Other Legally Authorized Representative

I permit the following confidential information about the client to be exchanged:

- Yes No Assessment Information, Benefits/Services Needed, Planned, and/or Received, Medical Diagnosis, Mental Health Diagnosis, Medical Records, Psychological Records, Educational Records, Psychiatric Records, Criminal Justice Records, Employment Records

Other Information (write in):

I agree for VEFC to contact me to evaluate and assess VEFC services. I understand my refusal to authorize this contact will not impact the availability of VEFC services.

I permit this information to be exchanged ONLY for the following purpose(s):

- Service Coordination & Treatment Planning Eligibility Determination

Other (write in): _____

I permit this information to be shared: (check all that apply)

- Written Information In Meetings or by Phone Computerized Data

I want to share additional information received after this consent is signed: Yes No

This information may be used only for the purpose(s) noted below:

- Yes No Facilitating treatment & treatment planning at referring agency, VEFC Funding and monitoring

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

- HIV(AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, or Drug and /or alcohol use.

This consent is good until: _____ I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need. I have read this form and had it explained to me. I understand its contents.

Signatures:

Parent/Guardian

Address: _____

Phone: (H) (_____) _____

(W) (_____) _____

Date

One Copy - FAX or Mail to VEFC Central Office

One Copy for Agency

One Copy: Host Family

One Copy: Parent/Guardian

Youth

Witness: _____
Agency Representative

Phone: (W) (_____) _____

Date