Head Start

"Building partnerships, changing lives"

Mental Health Child Find

Student Name: _____ Date of Birth: _____
Parent/Guardian: _____
Address: _____ City: _____

School District:_____ County:_____

Primary concern or area(s) of delay
_____Behavior
_____Other_____

OUTCOME
_____Did not qualify for service
_____Declined services
_____Receiving Outside Services _____
_____Receiving Services from Mental Health Provider

I authorize CSNT Head Start to share the following information with the referring practice/agency listed above.

- □ Eligibility outcome information (eligible/not eligible)
- □ Evaluation/Assessment results (range of delay for each developmental domain)
- □ Ongoing Early Intervention Services included on the Individualized Family Service Plan for the purpose of care coordination

I understand that I may withdraw this consent by written request to CSNT Head Start Program. If consent is revoked it does not apply to any actions that occurred before consent was revoked.

I certify that this authorization to release this information has been given freely and voluntarily. Information collected related to early intervention services may not be shared unless the person who consented to sharing this information specifically consents to it and or the sharing information is allowed by law. I understand I have a right to inspect and copy the information to be disclosed.

Signed: _____ Date:_____
(child's parent or legal guardian)

*Authorization is effective for a period of 24 months from this date

Mental Health Advocate:_____

Revised 4/9/2021