R.E.A.C.H.

Reaching Educational Achievements with Clinical Mental Health Counseling

Located at Conemaugh Township Area Elementary

1516 Tire Hill Road
Johnstown, Pennsylvania 15905
Phone: 814-479-4080

CONSENT TO RELEASE INFORMATION
Active for the 2024-2025 School Year

Child's Name: _____Date of Birth:_____

Grade/Homeroom Teacher: _____

I hereby authorize the Conemaugh Township Area School District to release and receive confidential information on the above-named child under the following terms:

Parent/Guardian initial to indicate consent:

_____ location of student in the CTASD Building
_____ release information from CTASD to R.E.A.C.H.
_____ release information from R.E.A.C.H. to CTASD

Information will be shared for the sole purpose of coordination of care efforts between CTASD and R.E.A.C.H.

Shared information may include, but is not limited to the following:
Location of student in CTASD building, educational information, verbal communication about mental health services, school-based concerns, written summary of progress.

*I understand that I may refuse to sign or revoke this authorization at any time without it affecting my child's ability to obtain services.
*Release must be given for the location of the child to be shared between CTASD and R.E.A.C.H. for services to be provided.

_____ _____
Signature of Parent or Legal Guardian Date

Over →

Limits of Confidentiality in Conemaugh Township Area School District

1. If an individual discloses Suicidal Thoughts with suicidal plans, Intent, means
2. If an individual reports Child Abuse or Child Neglect
3. Report of immediate Self-Harm Behaviors or plans to harm self
4. Specific Plans of violence toward others: Verbalized or Expressed Intent to harm others
5. Current Drug or Alcohol Use if client displays visible impairment or discloses use in the school setting
6. Upon receipt of a legitimate subpoena or court order

I understand that all professional efforts will be made to ensure the Client's Protected Health Information will be kept secure following HIPAA guidelines and only released under terms above or with signed release of information by client over 14 years of age or Parent/Guardian if under 14 years of age. By signing below, I understand and agree to the terms of confidentiality and HIPAA compliance.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

By initialing, I am giving permission to use the following forms of communication to be contacted by therapist throughout treatment. I understand confidentiality cannot be ensured completely through texting, email, or communication notebook. However, every attempt will be made by therapist or staff to ensure confidentiality is maintained.

Phone: _____Call or Text_____
Primary Phone number Parent/Guardian Name

Phone: _____Call or Text_____
Primary Phone Number Parent/Guardian Name

Email: _____ _____
Email address Parent/Guardian Name

_____Communication notebook sent back and forth from school to home