ArkSTART Consent for Release of Information

Complete all three portions of referral packet and fax to 844-834-2678 OR call 888-570-2146 to begin a referral.

A referral is not considered complete until the Rapid Referral Form, Consent for Release of Information, and Consent for Treatment are completed.

Office Use Only
Client ID:
Date Received:
Received by:

Referrals meeting requirements will be assigned a START Coordinator. Visit our website at www.ArkSTART.org for more information.

Individual's Name: Date of Birth:

I authorize the list of agencies below to communicate/share/disclose information to ArkSTART for the purposes of assessment and treatment planning, share information relevant to treatment and coordination of treatment services. Agencies authorized are as follows (List all current and past services including Day Services, Primary Physician, Psychiatrist, Consulting Physicians, Residential Services, Hospitals, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

Information to be disclosed includes: Intake Assessments, Person Centered Service Plan (PCSP), Treatment Plans, Positive Behavior Support Plan (PBSP), Psychological Testing, Psychological Evaluations, Psychiatric Evaluations, Social History, Physicals, Medical History, Physical Therapy Evaluations, Occupational Therapy Evaluations, Speech Evaluations, Discharge Summaries, Behavior Reports, Individualized Education Plan, Alcohol/Drug Treatment Information, other (listed below):

- Unless specifically requested in writing, that the disclosure be made in a certain format, information may be disclosed in any manner that is deemed to be appropriate and consistent with applicable law.
- I understand that I have a right to revoke this authorization, in writing, at any time and the revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I further understand that in any event this authorization expires automatically as follows: _____, or if unspecified, one (1) year after the dated signature (below).
- I understand that information may not be protected from re-disclosure by the requestor of the information. Redisclosed information may include information regarding drug abuse, alcohol abuse, HIV infections, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.
- I understand that I may request a copy of this signed authorization.

Verbal consent: Requires two (2) witnesses to the consent and a follow-up written consent for authentication.

_____

Signature of Individual (if no Legally Responsible Person has been appointed) Date

_____

Signature of Legally Responsible Person Date Authority of Legally Responsible Person

_____

Witness as Necessary Date Witness as Necessary Date