Spero Home Visiting Referral

SPERO FAMILY SERVICES
HOPE • HELP • HEALING
SPEROFS.ORG

Date of referral: _____ DCFS ID if applicable: _____

Referred by: _____ _____
Name of DCFS/POS worker Agency Name & Location

Phone:_____

Email:_____

Names family members and ages of children being referred:

Name:_____Age:_____

If expecting, how many weeks pregnant or EDC? _____

Name:_____Age:_____
Name:_____Age:_____
Name:_____Age:_____

Family Contact Information

Phone:_____

Address:_____

Child and Family strengths/interests:

_____

_____

Child and Family needs/reason for referral:

_____

_____

_____

Safety Concerns:

_____

Please submit form and/or questions to email ***hvs@sperofs.org***
*phone:****618-315-3003*** *fax* ***866-535-7465***

Office Use Only:

- Referral forwarded to PAT NPP NFP Other:_____on _____
- Referral declined by participant _____
- Referral unable to be reached/letter mailed_____

Spero Family Services Authorization for Release of Information

I,_____, authorize, Spero Family Services (Agency/Facility/Person)

to: ☐Release to: ☐Obtain from: ☒Exchange with:

_____, (Agency/Facility/Person)
(Address)

Information concerning_____DOB____/____/____.

Specific Nature of Information: ☐ Social History ☐ Medical Records ☐ School Records/IEP
☐ Admission/Discharge Summaries ☐ Progress Notes & Incident Forms
☐ Psychiatric or Psychological Assessments ☐ Court Orders/ Legal Concerns
☒Other Information needed to complete referral and intake into services provided by Spero Family Services.

This information may be released by mail, phone, fax, electronic transmission, or verbally and will be used for the purpose of: ☐ Provision of Social Services ☐ Provision of Special Education ☐ Casework Planning

☐ Other_____

This authorization is valid until___/___/_, unless otherwise revoked.
Consents for release of information are valid for a maximum of one year; one time release of information is valid for a maximum of 90 days.

I understand that I may revoke this consent at any time, and that such revocation must be in writing.
I further understand that above named agency/facility/person authorized to receive this information has the right to inspect and copy the specific information being disclosed.

I understand that if I refuse to authorize this release of information the following consequences may occur: the Agency will be unable to receive the requested information and may affect the decisions regarding my referral, progress, and/or provision of services.

It is my full understanding that the records and communications to be disclosed contain evaluation and/or habitation/treatment information for mental health, developmental disabilities and/or alcohol or substance use/abuse and that my signature indicates my informed consent.

X_____
(Signature of client age 12 or older) (Date)

X_____
(Signature of Parent/Guardian of client) (Date)

X_____
(Witness) (Date)

A copy of this consent from was given/mailed to the client on:___/___/_____ _____
(Worker's signature)

Notice to receiving agency/facility/person: Under penalty of law and the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), you my not redisclose any information unless the person who consented to this disclosure specifically consents to such redisclosure. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without specific authorization for such redisclosure. Under the Illinois HIV/AIDS Confidentiality act, no records or information may be disclosed without specific authorization for such disclosure.