**SCHOOL STUDENT REFERRAL FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Consumer Information:**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | |  |  | |  |  | | | Name | | |  |  | |  | Date of Birth | | |  | | |  |  | |  |  | | | Address | | |  |  | |  | Phone | | |  | |  |  |  | |  | |  | | Email | |  |  |  | | Parent/Guardian Email | | | |  |  | |  |  |  |  | | | | Disability |  | |  |  | Parent/Guardian Phone | | | | | | | | | |
| Other Services Being Provided/Referred: | |  |  | |
|  | Vocational Rehabilitation Services (VRS) |  | Adult Basic Education (ABE) | |
|  | County Case Management |  | Other: |  |
|  | Psychological/Psychiatric Services |  | Other: |  |

**Release of Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| I, |  | hereby authorize |  |
|  | Consumer’s Name |  | Referral Source |

to release the information on this form to SWCIL. I have been advised that this information will be kept confidential and will be used only to aid SWCIL in assisting me to pursue independent living services and, if appropriate, in the development of my service plan.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Consumer |  | Date |
|  |  |  |
| Signature of Parent/Guardian (if necessary) |  | Date |

**Referral Source:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Agency/School |  | Contact Person & Title |
|  |  |  |
| Address |  | Phone |
|  |
| Email |
|  |  |  |
| Referral Signature |  | Date |

**Please provide reason for referral and other information to assist SWCIL staff in delivering services (i.e. – areas of need, situation, employment status, best time to contact, etc.). Please be as specific as possible.**

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**Authorization for the Release of Information**

SWCIL coordinates with Vocational Rehabilitation Services for the purpose of making appropriate referrals, to avoid duplication of services, and to coordinate independent living and employment related services to best meet the needs of consumers.

|  |  |
| --- | --- |
| Person whose information is to be released: |  |

|  |  |  |
| --- | --- | --- |
| I, |  | hereby authorize and give my permission for the |
|  | Name of Person Releasing Data |  |

|  |
| --- |
| Southwestern Center for Independent Living (SWCIL) to gather and/or exchange information regarding independent living services provided and/or requested (data, records, type or nature of information authorized to be disclosed) with the following agencies: |

|  |  |
| --- | --- |
| * Vocational Rehabilitation Services | |
| * Other: |  | |
| * Other: |  | |

|  |  |  |
| --- | --- | --- |
| This authorization expires on |  | or within one (1) year, whichever is earlier. |

|  |
| --- |
| I understand that my information may be protected under State and Federal privacy regulations, and if so, cannot be disclosed without my written consent unless otherwise provided for by law.  I also understand that I may cancel this authorization at any time prior to the information being released and that in any case this authorization automatically expires one (1) year after I sign it. |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Consumer |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Parent/Guardian (if necessary) |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Southwestern Center for Independent Living |  | Date |

***A photocopy of this authorization shall be treated in the same manner as the original.***

3/21/22