REGION IX SCHOOL BASED HEALTH CENTER
BECAUSE HEALTHIER STUDENTS LEARN BETTER
125 Warrior Drive Ruidoso NM 88345

Complete all areas that apply. Please tell us who referred you and bring this form with you on your group intake appointment. Note: Circle of Security Parenting Group Sessions are $25.00 per session (total of 8) if you do not have proof of Medicaid Insurance.

Court
___District __Municipal ___ Misdemeanor Compliance
___Magistrate __ Drug Court ___Truancy

Other Referring Individual or Agency

____ Counselor/Therapist Other_____

Children Youth and Families
___CPS ___JPPO ___APPO

Name (print)
_____

Mailing Address: _____City _____ Zip _____

Phone Numbers: Home _____Work_____ Cell_____

Age_____ Male _____ Female____

Please mark ethnicity below:

White/Caucasian ____Black/African American ____Hispanic/Mexican/Spanish_____
Native American/Indian American_____ Tribe_____ German _____
Asian/Chinese/Japanese/ Korean ____Bi racial____ other ethnicity not listed_____

Ages of your children: _____

Signature_____ Date _____

Region IX Education Cooperative School Based Health Center
237 Service Road Ruidoso, NM 88345
Phone 630-7974 Fax 258-3320

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Release of Information

I, _____ _____ _____
(Parent)Print Name Social Security Number Date of Birth

AUTHORIZE SCHOOL BASED HEALTH CENTER STAFF
To release my records to:

Referring Agency_____
Referring Person's Name_____
Agency Phone Number: _____Agency Fax Number_____
AgencyAddress_____
City, State, Zip_____

Alcohol/drug /infectious disease/psychiatric records are protected by federal regulation 42CFR, part 2. And release of these records requires specific consent. This authorization covers **ALL** records and information as well as verbal and facsimile communication and provides specific consent necessary for the release of the following: drug or alcohol abuse, infectious diseases (including HIV), and psychological or psychiatric problems unless otherwise specified below:

_____

_____

This disclosure is being made for the following purpose(s):
___ Attorney/Court Case___ Personal Reasons Other: _____

This authorization for disclosure of information is effective for one year from date signed. This authorization is subject to revocation at any time by written notification only. A copy of this authorization shall serve the same purpose as the original signed document.

Signature: _____ Date: _____

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