

## Consent for Referral and Participation

Medical Record #:

I give my consent to \_\_\_\_\_ to refer my child and family members as identified to the St. Croix County Coordinated Family Services. I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in the Coordinated Family Services, it will be necessary for service providers to routinely review and share information.

\_\_\_\_\_  
Signature of Individual Authorizing Referral

Date \_\_\_\_\_

\_\_\_\_\_  
Second Authorization/Witness Signature

Date \_\_\_\_\_

