**CLIENT INFORMATION** [Please Print]:

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF LIABILITY, AGREEMENT AND CONSENT**:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to receive

**[Please Print] Parent/Legal Guardian Name**

Wraparound services for myself and/or my minor-aged child provided by Collaborative Change.

I understand that my signature below constitutes written permission for the service provider to share information obtained during the course of wraparound services to the clinical supervisors and HSPP at Collaborative Change.  
  
I understand that, while every effort will be made to protect the privacy of myself and/or my minor-aged child, wraparound services take place in the community, are family driven and thrive off incorporating natural supports. Therefore, I will not hold Collaborative Change and any of its contracted affiliates responsible if I and/or my minor-aged child come in contact in the community with others where confidentiality may be compromised, if I invite or give verbal permission for my minor-aged child to invite a natural support to a team meeting or session with service provider. Due to the nature of wraparound services I understand that my confidentiality and that of my minor-aged child may be compromised when I choose to incorporate natural supports into services and I will not hold Collaborative Change and any of its contracted affiliates responsible for possible compromised confidentiality when I invite natural supports to engage in wraparound services with myself and my minor-aged child.  
  
I hereby assume any and all risk and liability for losses or damages to property, injuries, or death of myself and/or my minor-aged child which may arise in connection with participation in wraparound services provided by Collaborative Change and any of its contracted affiliates, and hereby, for myself and/or my minor-aged child, our heirs, executors, administrators, successors and assigns, do release and discharge Collaborative Change and each of their contracted affiliates from any and all claims, actions, and liabilities arising from participation in wraparound services.

I authorize Collaborative Change and any of its contracted affiliates to release information about myself and/or my minor-aged child to any/all Wraparound Team Members, including but not limited to the Wraparound Facilitator, Therapist, Life Skills Specialist, Case Manager, Psychiatrist, School Personnel, Probation Officer, Department of Child Services Case Manager/Supervisor, Judge/Court Hearing, Natural Supports, Habilitation, etc.

If there are any individuals or service providers that you do not want to participate in services and do not wish to have Collaborative Change to have contact with or share information with please write those names here:

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**Parent/Legal Guardian Signature Date Relationship to Child**

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**Witness Signature Date**