

VENTURA COUNTY SPECIAL EDUCATION LOCAL PLAN AREA (SELPA)

5100 Adolfo Rd., Camarillo, CA 93012

CONSENT FOR MENTAL HEALTH REFERRAL

Student Name: _____ Birthdate: _____

As the Parent(s)/Legal Guardian/Surrogate of student named above, (I, we) hereby give consent for the _____ School District to refer our (son, daughter) to the Ventura County Behavioral Health Department for assessment for educational services under Chapter 26.5 of the Government Code. This consent includes:

1. Consent to refer for evaluation and assessment;
2. Consent to allow school district to send the following records to the Behavioral Health Department:
 Medical Medication Mental Health Psychological or Counseling
 Educational Other (specify): _____
3. Consent to allow a mental health professional or designee to observe the student in a school setting and discuss pertinent information with school district personnel, as needed.

(I, we) understand that I have the right to refuse the exchange of specific documents. If I have further questions I will contact the person below.

(I, we) understand that permission to assess and exchange information does not automatically mean that the student will receive mental health services under Chapter 26.5 of the Government Code through Ventura County Behavioral Health. If the student is eligible, services will be developed through the IEP process.

This consent remains in effect from date of signature until revoked. I understand I may revoke consent at any time. Written revocation will be effective upon receipt, but will not apply to information that has already been released as a result of this authorization.

A copy of this authorization is valid as an original. I understand I have the right to receive a copy of this authorization for my records.

Date

Signature of Parent/Legal Guardian/Adult Student/Surrogate

Home Address

City, State, Zip

Home Phone (_____) _____

Business Phone (_____) _____

School District Contact Person:

Name

Title

Phone number