Consent/Authorization Form for Child Medical & Child/Family Evaluations

Name of Child_ enter name Date of Birth enter a date.
Name of Child_ enter name Date of Birth enter a date.
Name of Child_ enter name Date of Birth enter a date.

I hereby authorize enter name of Examiner to perform:

☐ A Child Medical Evaluations (CME), including diagnostic studies and photographs, on the above-named child.
☐ A Child/Family Evaluation (CFE), including diagnostic studies, on the above-named child.

Furthermore, I authorize the above-named examiner to release the entirety of the medical record to (All items must be checked):

☐ A county department of social services (DSS) providing protective services to the above-named child
☐ NC Child Medical Evaluation Program (CMEP)
☐ NC Division of Social Services

☐ I understand that, as the parent/legal guardian, I will not have access to Child Medical Evaluation or Child & Family Evaluation reports.
☐ I understand that limited information can be shared with the parent/legal guardian and medical and/or mental health professionals providing care to the child post-evaluation. This may include:
- Mental health symptoms
- Physical exam findings
- Laboratory studies

☐ I acknowledge that this evaluation is used to make determinations of child maltreatment and is a component of a NC child protective services assessment.

This referral is made by authority of (check one):

☐ Parent
☐ Legal Guardian
☐ DSS Director - When acting as temporary guardian of a child found abandoned or without a natural guardian (G.S. § 35A-1220) or when having been vested with parental rights by the adoption or termination of parental rights laws (G.S. §§ 48-3-705 and 7B-1112).
☐ Judge's Order - In accordance with G.S. § 7B-505.1, when a court order authorizes this evaluation.

_____ Date: Click or tap to enter a date.
Signature of parent/guardian

Please complete form on page 2

(To be completed by the referring county DSS)

The provider listed above is authorized to claim reimbursement in accordance with the Purchase of Service Contract for the services, if child is the subject of an open CPS Assessment and a county child welfare agency has referred the child for a CME/CFE.

Case open for CPS Assessment (Service Code 210 and 212): ☐ YES ☐ NO
County: [enter name] SIS or CNDS#: Click or tap here to number.

Is Medicaid the primary insurer: ☐ YES ☐ NO Medicaid# [Click or tap here to number.

I authorize the referral for the above-named child(ren) to receive a CME/CFE at the request of [enter name] County DSS.

_____Date: Click or tap to enter a date.
Signature of county DSS representative

County Child Welfare worker: Click to enter name Phone: Click to enter number
Email: Click here to enter email

County Child Welfare supervisor: Click to enter name Phone: Click to enter number
Email: Click here to enter email