Georgia Public Defender COUNCIL

270 Washington Street
Suite 6079
Atlanta, GA 30334
404-795-2440
www.gapubdef.org

Client Support Services Unit Informed Consent

1.) **Client Support Services** is a voluntary collaborative process that is intended to assist you with addressing the issues that has caused criminal system involvement. A team of social workers partner with your public defender to help improve your circumstances.

2.) **Time Parameters** are at minimum 3-months for your social worker to assess your needs, target goals, identify resources, and track progress in services, if applicable. However, you have the right to cancel services at any time and are encouraged to first consult with your attorney about your choice to cancel. To restart services, please contact your attorney to be reconnected with a social worker.

3.) **Confidentiality** is critical to the client-social worker's relationship and it is the duty of your social worker to protect your records or other information collected about you and will be held confidential with respect to state laws. Your records cannot be released by your social worker without your signed permission. However, there are a few situations that your social worker has an ethical and legal duty to make an exception for. These situations include:

1. If you disclose pending thoughts of harm to yourself or someone else.
2. If your social worker becomes aware of any abuse or neglect happening to you.
3. If a court orders the release of you records.

4.) **Electronic Transmission:** Your social worker cannot ensure the confidentiality of any form of communication transmitted via electronic devices. You are advised that any email or message sent to your social worker via any electronic device and through social media is open access to the public.

I _____ have read, understood, agree, and consent to the above conditions of service stated. I give my consent to receive case management support from the Georgia Public Defender's Client Support Services Unit (CSSU). I further acknowledge that there is no guarantee that a favorable decision will be made in my legal case or in improving my life circumstances. Moreover, I understand that any support I receive from my social worker will be a cooperative effort between me and my social worker.

_____

Client Signature **Date**

_____

Witness Signature **Role of Witness** **Date**

Client Intake Sheet
GPDC Client Support Services Unit

Georgia Public Defender Council

Client Information

Client's Full Name:	Today's Date:
Client's Phone/Contact Info:	DOB:

Once released, where would you live? ☐ With family ☐ With friends
☐ In a Shelter
☐ Don't know ☐ Other (write in):

Name of person or agency you will live at once released:

Address/Phone Number of the person or agency:

Education History

Educational Level (select one): ☐ 12th grade or less
☐ Completed High School or GED
☐ Some college or technical school
☐ College Graduate
☐ Decline to share

Client Social Support Contacts

Name	*Relationship Type*	*Contact*

Brief Needs Assessment (check all that apply)

☐ Food	☐ Shelter
☐ State ID	☐ Social Security Card
☐ Transportation (for doctor appointments/treatment, etc.)	☐ Counselling
☐ Employment	☐ Medical/Dental
	☐ Other

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Authorization to Release Information

GPDC Client Support Services Unit

Full Name of Individual: _____ **Date of Birth:** _____

1.) I hereby authorize:

_____

(Name of person or agency to whom information should be given)

To Obtain the requested information from:

_____

(Name of healthcare provider, school, or other releasing agency not mentioned herein)

2.) Please check all information you authorize for release:

☐ Criminal history information ☐ Employment history ☐ Status updates ☐ Financial history	☐ Housing history ☐ Medical history ☐ Mental health records ☐ School records	☐ Communications regarding services/treatment ☐ Medications (current & past) ☐ Substance treatment records ☐ Other information (please specify): _____ _____

3.) The above authorized disclosure information is for the Purpose of: _____

_____

4.) I understand that authorizing the above disclosure information is voluntary. I can refuse to sign this authorization.

5.) I understand that by signing this authorization, my treatment, payment, and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

6.) I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidential rules.

7.) I may revoke this authorization by notifying the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street, N.W., 15th Floor, Atlanta, Georgia, 30303, and include your name, date of birth, social security number, and the location where services were received if services were received at a local county health department.

I can also revoke this authorization in writing by notifying the Georgia Public Defender Council's Client Support Services Unit at 270 Washington Street, S.W., Suite 6079, Atlanta, Georgia 30334. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8.) I understand that this authorization expires **one year from the date of my signature.**

_____	_____	_____
Signature of Individual	Print Name	Today's Date
_____	_____	_____
Signature of Guardian/Representative	Print Name	Today's Date
_____	_____	_____
Signature of Witness	Role of Witness	Today's Date