

Georgia Public Defender Council-Social Services Department  
Client Support Services Informed Consent



**1. Purpose of Client Support Services**

Client Support Services is a voluntary and collaborative program aimed at helping you address factors that may have contributed to your involvement in the criminal justice system. Our team of social workers collaborates with your public defender to work on improving your personal circumstances.

**2. Duration and Termination of Services**

The recommended timeframe for support services is at least three months. During this period, your social worker will assess your needs, set goals, connect you with resources, and monitor progress in services where applicable. You have the right to discontinue services at any time, though it is advised to first discuss this decision with your attorney. If you wish to resume services after cancelation, please contact your attorney to be reconnected with a social worker.

**3. Confidentiality**

Confidentiality is a core part of the relationship between you and your social worker. All information gathered about you will be kept confidential according to state laws, and your social worker will not release your records without your signed consent. However, confidentiality may be legally and ethically breached in the following situations:

- If you express intentions of harm to yourself or others
- If there is knowledge of any abuse or neglect involving you
- If your records are required by a court order

**4. Electronic Communication**

Your social worker cannot guarantee the confidentiality of communications shared through electronic methods, including email, text, or social media. Please note that these channels may be accessible to the public.

**Consent Statement**

I, \_\_\_\_\_, have read, understood, and agree to the terms outlined above. I give my consent to receive case management support from the Georgia Public Defender Social Services Department - Client Support Services. I understand that this support is a cooperative effort between myself and my social worker, and that there is no guarantee of a specific outcome regarding my legal case or personal circumstances.

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**Client Signature**

**Date**

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**Witness Signature**

**Role of Witness**

**Date**



# Client Intake Sheet

GPDC Social Services Department-Client Support Services

## Client Information

|  |               |
|--|---------------|
| Client's Full Name:  | Today's Date: |
| Client's Phone/Contact Info:   | DOB:          |
| Once released, where would you live? <input type="checkbox"/> With family <input type="checkbox"/> With friends<br><input type="checkbox"/> In a Shelter<br><input type="checkbox"/> Don't know <input type="checkbox"/> Other (write in): |               |
| Name of person or agency you will live at once released:   |               |
| Address/Phone Number of the person or agency:  |               |

## Education History

|  |
|--|
| Education Level (select one):<br><input type="checkbox"/> 12 <sup>th</sup> grade or less<br><input type="checkbox"/> Completed High School or GED<br><input type="checkbox"/> Some college or technical school<br><input type="checkbox"/> College Graduate<br><input type="checkbox"/> Decline to share |
|--|

## Client Social Support Contacts

| <i>Name</i> | <i>Relationship Type</i> | <i>Contact</i> |
|-------------|--------------------------|----------------|
|             |                          |                |
|             |                          |                |

## Brief Needs Assessment (check all that apply)

|  |   |
|--|---|
| <input type="checkbox"/> Food<br><input type="checkbox"/> State ID<br><input type="checkbox"/> Transportation (for doctor appointments/treatment, etc.)<br><input type="checkbox"/> Employment | <input type="checkbox"/> Shelter<br><input type="checkbox"/> Social Security Card<br><input type="checkbox"/> Counseling<br><input type="checkbox"/> Medical/Dental<br><input type="checkbox"/> Other |
|--|---|



# Authorization to Release Health and Personal Information (HIPAA Compliant)

GPDC Social Services Department-Client Support Services

Full Name of Individual: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## 1. Authorization to Release Information

*I hereby authorize:*

Name of Person or Organization: \_\_\_\_\_

*To Obtain the requested information from:*

Name of Person or Organization: \_\_\_\_\_

## 2. Information Authorized for Release

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. Purpose of Disclosure

The information is authorized for disclosure for the following purpose(s):

\_\_\_\_\_

## 4. Voluntary Authorization

I understand that authorizing the disclosure of the above information is voluntary and that I may refuse to sign this authorization.



**5. No Condition on Services**

I understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on my signing this authorization.

**6. Potential for Re-disclosure**

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality rules.

**7. Revocation of Authorization**

I may revoke this authorization at any time by notifying the Privacy Officer, Office of the General Counsel, Georgia Department of Public Health, 2 Peachtree Street NW, 15th Floor, Atlanta, Georgia 30303. My request must include my name, date of birth, social security number, and location where services were received if applicable.

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

**8. Expiration**

This authorization expires one year from the date of my signature, unless an earlier date is specified here:

\_\_\_\_\_

**Signature and Date**

Signature of Individual: \_\_\_\_\_

Print Name: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

**Signature of Guardian/Representative (if applicable):** \_\_\_\_\_

Print Name: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_

Role of Witness: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

**\*\*This form complies with the Health Insurance Portability and Accountability Act (HIPAA) requirements and aims to protect your privacy in the handling of your personal health and related information.**

