



Person/Agency Referring: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client's Phone Number: \_\_\_\_\_

- *Is this a safe phone number: Yes / No*
- *Is this safe to leave a VM: Yes / No*
- *Is this safe to text: Yes / No*

Perpetrator's Name: \_\_\_\_\_

*Type of Victimization:*

Domestic Violence

Sexual Assault

Assault

Child Sexual Assault

Stalking

Family Violence

Other: \_\_\_\_\_

Additional Referral Notes:

---

---

---

---

---

---

---

\* Due to our agency confidentiality, we will not be able to confirm or deny if we have been able to have contact with the client *unless* the client has signed a release of information with ALC. Please feel free to have the client fill out a release form (attached) and send it over with this referral form.

***Please send all referrals to [admin@advocatesoflakecounty.org](mailto:admin@advocatesoflakecounty.org).***

Advocates of Lake County

I understand that The Advocates of Lake County (ALC) has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow ALC to release some of my personal information to certain individuals or agencies.

I, \_\_\_\_\_, authorize ALC to share the following specific information with:

Who I want to have my information:	Name:
	Specific office at agency:
	Phone number:

The information will be shared:  in person  by phone  by fax  by mail  by email  
 I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What information will be shared:	(List as specifically as possible, for example: name, dates of service, any documents.)
Why I want my information shared: (purpose)	(List as specifically as possible, for example: name, dates of service, any documents.)

Please note: there is a risk that a limited release of information can potentially open-up access by others to all of your confidential information held by ALC.

I understand:

- That I do not have to sign this release form. I do not have to allow ALC to share my information. Signing a release for is completely voluntary. That this release is limited to what I write above. If I would like ALC to release information about me in the future, I will need to sign another written, time-limited release.
- That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from ALC.
- That ALC and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.
- That I am able to speak to any person at any time about my situation, but my advocates can only speak to the agency or person designated on this release.
- That I do not have confidentiality in public places or when a third party is present.

This release expires on \_\_\_\_\_ *Expiration should meet the needs of the victim, which is typically no longer than 15-30 days, but may be shorter or longer.*  
(Date) (Time)

Or, this release expires in (circle one) 1 7 30 90 365 days from today at 5:00PM.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at anytime either orally or in writing.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Time: \_\_\_\_\_

Witness: \_\_\_\_\_

**Reaffirmation and Extension (If additional time is necessary to meet the purpose of this release)**

I confirm that this release is still valid and would like to extend the release until (Date) \_\_\_\_/\_\_\_\_/\_\_\_\_ (Time) \_\_\_\_:\_\_\_\_:\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Signed: \_\_\_\_\_ Witness: \_\_\_\_\_