Consent Form for Child Medical Evaluation

Name of Child: Date of Birth:

I hereby authorize ______________________________ to perform a: _________________________________
Child Medical Evaluations (CME), including diagnostic studies and photographs, 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 the CME report.
☑ 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 the 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:_________________________
Signature of parent/guardian

<u>Please complete form on page 2</u>

<u>(To be completed by the referring county DSS)</u>

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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.

Case open for CPS Assessment (Service Code 210 and 212): ☐ YES ☐ NO
County:_________________ SIS or CNDS#: ___________________________

Is Medicaid the primary insurer: ☐ YES ☐ NO Medicaid# _________________________

I authorize the referral for the above-named child(ren) to receive a CME at the request of_______________County DSS.

____Date: ________________________
Signature of county DSS representative

County Child Welfare worker: Phone:
Email:

County Child Welfare supervisor: Phone:
Email: