Community Mediation Center
2515 College Avenue
P.O. Box 276
North Newton, Kansas 67117-0276
Tel. 316-284-5829
Fax 3160284-5379
Email *cmc@bethelks.edu*

HOPE PROGRAM WAIVER OF CONFIDENTIALITY

I, _____, am a legal parent of the following child/children:
(Printed name)

Child's Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

On behalf of the above child/children and on my own behalf, I grant to a representative from KIPCOR's Community Mediation Center's HOPE (Healthy Opportunities for Parenting Effectively) program the right to ask for, receive and/or discuss any information, oral or written, or to request and receive any document or record pertaining to my named child/children and/or to me for the purpose as explained below. This waiver of confidentiality shall apply to information from my attorney and/or case manager, a representative of the 9th Judicial District Court, a law enforcement official, a mental health or drug rehabilitation professional, SRS, and/or any other person/agency that referred me to the HOPE program. Information may be shared with others assisting with the HOPE classes.

I understand that information requested will be for the purpose of helping the leaders of the HOPE program understand the situation that resulted in my referral to the HOPE program, especially as it affects my child/children. I indemnify and hold harmless the HOPE representative(s) and any person or entity who provides information to her/him/them.

I acknowledge that a photocopied, faxed, scanned, or e-mailed copy of this document carries the full force and authority of the original. I understand that this waiver shall expire thirty (30) days after I have completed the HOPE classes.

By my signature below, I acknowledge that I have read and understand the above statements.

Signature: _____ Date: _____

Date of Birth: _____ Court Case Number: _____