



**STRATFORD JUVENILE REVIEW BOARD**

Police and Juvenile Court Referral Form

Youth Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Referral Source: \_\_\_\_\_ Referral Date: \_\_\_\_\_  
 Referral Source Contact: \_\_\_\_\_ Case Number: \_\_\_\_\_  
 Reason for Referral: \_\_\_\_\_

**Notice, Waiver of Rights and Consent to Release Information**

**Youth:** I would like my case diverted to the Stratford Juvenile Review Board (JRB). I have been advised of my right to confidentiality regarding my juvenile arrest, court record and history. I hereby waive this right and consent to have the Police Department and Juvenile Court provide information to the Stratford Juvenile Review Board to determine eligibility for my case. If my case is eligible, I agree to work with the JRB to develop an appropriate reparative action plan to resolve this matter.

**Parent/Legal Guardian:** I/We agree and consent to the terms and conditions of the above Notice, Waiver and Release of Information. I/We authorize information regarding this case be provided to the Stratford Juvenile Review Board. I/We agree to work with my/our child and the JRB to develop an appropriate reparative action plan to resolve this matter.

This authorization expires in one (1) year unless expressly revoked earlier or case is closed.

Youth Signature: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_  
 Parent/Guardian contact number(s): \_\_\_\_\_  
 Officer Name / Badge: \_\_\_\_\_  
 Officer contact information: \_\_\_\_\_

**SEND THIS SIGNED AUTHORIZATION-RELEASE AND RELEVANT DOCUMENTS TO STRATFORD JRB:**

MAIL	FAX / SCAN
Stratford Community Services 468 Birdseye Street Stratford, CT, 06615 <b>Attention:</b> Paige Morrisroe LMFT, Clinical Coordinator	Fax: 203 – 381 – 2064 E-mail: <a href="mailto:pmorrisroe@townofstratford.com">pmorrisroe@townofstratford.com</a>

**Once received, contact is made with Juvenile Court and Records Division/Stratford Police Department before intake at Stratford Community Services.**