DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

Report Control Number

RCN - 175

FAMILY ADVOCACY INFORMED CONSENT FAMILIES IN NEED OF SERVICE (FINS)

PRIVACY ACT STATEMENT

AUTHORITY:	5 USC 301; 14 USC 632; 44 USC Chapters 29, 31 and 33; 10 USC 1058 and 1059; COMDTINSTs 1752.1 (series) and 1754.16 (series)
PRINCIPAL PURPOSE:	This form provides you the advice required by the Privacy Act of 1974. The personal information will facilitate and document your care as a recipient of FINS services.
ROUTINE USES:	The primary use of this information is to provide, plan and coordinate FINS services. Other possible uses are to: compile statistical data; conduct research; teach, other lawful purposes, including law enforcement and litigation; and to evaluate rendered care. Information provided on this form will not be disclosed externally except in accordance with DHS/USCG-028 Family Advocacy Case Records Systems of Records, 73 FR 77782 (December 19, 2008).
DISCLOSURE:	Voluntary; however, failure to provide information may delay the provision of appropriate services to you.

The Family Advocacy FINS program is designed to strengthen and support the health and wellness of military families.

I understand that participation in the FINS program offered is completely voluntary and that I may choose to withdraw at any time without notice and without giving a reason.

I will be asked to participate in program assessment questionnaires. The data from these questionnaires will be analyzed as group data. Research findings NEVER include individual names or other identifying information.

I further understand there may be possible risks and benefits to participating. Possible risks: some questions may touch on personal or sensitive issues. Possible benefits: increased understanding of family issues and concerns, and skills in dealing with them; knowledge of health and self-care practices, and increased satisfaction with myself and other family members.

I understand that if at any time information I disclose has a bearing on my personal or my family's safety and/or medical needs, it may be necessary for you to communicate this information to a physician or appropriate Coast Guard personnel. In such a situation, I will be informed of the reasons for concern and the decision to relate this information.

I have read this form and fully understand benefits and risks. I agree to participate in the program.

SIGNATURE	DATE

I have reviewed the information on this form with the above-identified client to ensure he/she understands FINS Services informed consent policies.

SIGNATURE	DATE

Reset