AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

For use by a parent, dependent child 12 years or older and/or child's attorney to sign for the release from a single entity regarding the child's information to the Child and Family Team. Also for use by a parent or other adult to release their own health information to the Child and Family Team.

I hereby authorize use or disclosure of my health information as described below.

DATE:

CLIENT			
LAST NAME:	FIRST NAME:	INITIAL:	DATE OF BIRTH:
AKA'S:			

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:		
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		
TREATMENT DATES:	☐ AT THE REQUEST OF THE INDIVIDUAL.	

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING:

NAME OF ENTITY: THE CHILD AND FAMILY TEAM (CFT) MEMBERS, AS OUTLINED ON THE CHILD AND FAMILY TEAM CONFIDENTIALITY AGREEMENT (04-446), FOR THE PURPOSE OF ASSESSING, PLANNING, MONITORING AND REFINING THE YOUTH'S PLACEMENT AND THE FAMILY'S SERVICES ONLY DURING CHILD AND FAMILY TEAM MEETINGS RELATED TO SAFETY, PERMANENCY, AND WELL-BEING AS RELATED TO:

YOUTH'S NAME(S): **DSS #:**

This release does not apply to any communications or release of information outside the confines of the Child and Family Team meetings.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ Protected Medical Information including: history, treatment, progress, medication, laboratory results, and treatment recommendations

☐ Protected Mental Health Information including: history, evaluations, assessments/consultations, diagnosis, treatment, progress, treatment recommendations, and medication

☐ Protected Educational Information including: history, assessments, IEPs, progress, grades, behavioral plans, educational recommendations (Only signed by youth 18+ or educational rights holders)

☐ Protected Drug/Alcohol Information including: history, assessment, treatment, progress, medication, laboratory results, and treatment recommendations

☐ Other *(Provide description)* _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I will inform the social worker that I revoke my authorization. I understand that the revocation will not prevent use of information released prior to revocation.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (initial the first condition and one of the last two consistent with case status):

_____Upon removal of the provider from the Child and Family Team, as executed on the Child and Family Team Confidentiality Agreement (04-446).

_____ Upon closure of an out of home voluntary services case or one (1) calendar year from the date it was signed, whichever occurs first.

OR

_____ Upon termination of Juvenile Court jurisdiction for a dependency case or one (1) calendar year from the date it was signed, whichever occurs first .

Redisclosure: If I have authorized the disclosure of my or my child's health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

For parents of children in protective custody: I understand that HHSA may use this information to determine if my child should be made, or continued as a dependent of the Juvenile Court; whether my child should be removed from my custody and control, and if removed, to evaluate my progress in working to regain custody of my child. As part of a dependency action in the Juvenile Court, this information may be used to appoint a legal guardian or terminate the parental rights entirely for my child.

I have a right to receive a copy of this authorization. I would like a copy of this authorization: ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE		
SIGNATURE:	PRINTED NAME:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:		