CONSENT TO RELEASE CONFIDENTIAL INFORMATION

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH AND SUBSTANCE ABUSE INFORMATION**

1. **Family:**

**Identified Child** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case #: \_\_\_\_\_\_\_\_\_\_\_\_**

**Identified Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Identified Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **By signing this Authorization, I hereby voluntarily permit the use or disclosure of Protected Health Information (PHI) and Substance Abuse Information pertaining to me, my health, or my health care (including paper, oral, and electronic interchange) by and to the following individuals or organizations** *(check all that apply)***:**

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| **LANCASTER COUNTY PLANS OF SAFE CARE TEAM PARTNERS** | |
| Lancaster County Children and Youth Social Service Agency | **150 North Queen Street**  **Suite #111**  **Lancaster, PA 17603** |
| Lancaster County Behavioral Health and Developmental Services (BH/DS)  Early Intervention Program | **150 North Queen Street**  **Suite #517**  **Lancaster, PA 17603** |
| WellSpan Ephrata Community Hospital  Healthy Beginnings Plus (HBP)  Foundations Pregnancy Support Services (FPSS) | **169 Martin Ave. Ephrata, PA 17522** |
| UPMC Lititz | **1500 Highlands Drive**  **Lititz, PA 17543** |
| Lancaster General Hospital, Penn Medicine (LGH):  Women & Babies Hospital  Healthy Beginnings Plus (HBP)  Nurse Family Partnership | **555 N. Duke Street**  **Lancaster, PA 17602** |
| Drug & Alcohol Commission  The RASE Project, Lancaster | **131 East Orange Street**  **Lancaster PA 17602** |

|  |  |
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| **OTHER IDENTIFIED PROVIDERS/AGENCIES** | |
| Maternal and Child Health Agency: |  |
| Home Visitation Program: |  |
| Substance Use Disorder Prevention and Treatment Provider: |  |
| Mental Health Provider: |  |
| Managed Care Organization and Private Insurers: |  |
| Hospital or Medical Provider: |  |

|  |  |
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| **OTHER IDENTIFIED SUPPORTS** | |
| Name: | Relationship: |
| Name: | Relationship: |

1. The type and amount of information to be used or disclosed is as follows: (include dates or name of provider where appropriate). ***Check each category that applies:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medical**  **records:** | Entire Record | | Medications  Discharge plans  Billing Record  X-ray/imaging  Lab Results | | | |
| Mental Health Evaluation/Treatment  Treatment Progress/Cooperation/Compliance | | | | | |
| DATES: | |  | | From: | to |  |
| Drug and Alcohol **records:** | Entire Record  Medications  Discharge plans  Lab Results | | | | | |
| Drug/Alcohol Evaluation/Treatment  Treatment Progress/Cooperation/Compliance | | | | | |
| DATES: | |  | | From: | to |  |
| Day Care: | | | | Other: | | |

1. **Purpose for the Disclosure: (The information to be used or disclosed is to)**

Obtain or coordinate services and supports for a Plan of Safe Care relevant to my child’s and my well-being and health by a multidisciplinary team. Authorizing the disclosure of health and substance abuse information is voluntary.

Other:

1. **Persons Authorized to Use or Disclose: (The person(s) authorized to make the requested use or disclosure)**

Staff employed or contracted by the above specified provider.

Other:

1. **Persons Permitted to Receive the Information: (The person(s) to whom the use or disclosure may be made)**

Multidisciplinary Team partners and other identified providers/agencies identified above. Persons or business providers with which identified providers have entered service contract(s) or HIPAA Business Associate Agreements.

Other:

1. **Voluntary Consent:** Your authorization to disclose health information and substance abuse information is voluntary. You can refuse to sign this form. You need not sign this form to obtain treatment. If you have any questions about disclosure of your health or substance use information, contact the provider’s privacy officer.
2. **Expiration Date or Event:** This authorization shall remain in force until you are no longer in need of the identified services or until revoked; unless a different event or date is specified here:
3. **Right to Revoke:** You have the right to revoke this Authorization at any time and may do so by contacting the provider’s records department. If we have already used or disclosed your protected health information or substance abuse information before receiving your revocation, you understand that we cannot take back those uses or disclosures.
4. **Condition of Treatment:** If you do not sign this form, the providers involved may still determine that you need treatment/services. In those situations, as permitted by law, your care will be authorized by that provider and it will be noted in your record that an attempt was made to have you sign this form.
5. **Information May be Re-disclosed:** Information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be subject to privacy protections provided by law.

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| Printed Name of Mother or Legal Representative | | | Signature of Mother or Legal Representative | | | | | Date / Time | | |
|  | |  |  | | |  | | |  | |
| Printed Name of Father or Legal Representative | | | Signature of Father or Legal Representative | | | | | Date / Time | | |
| **For those individuals physically unable to sign this document:** | | | | | | | | | | |
| I, , am physically unable to sign this authorization. My verbal understanding of this document is hereby witnessed by the individual whose signature appears below. | | | | | | | | | | |
|  |  |  | |  |  | |  | | |  |
| Witness Printed Name |  | Date | |  | Witness Signature | |  | | | Date |