Child and Family Team
Authorization for Use of Protected Health and Private Information

CHILD NAME: _____
DATE OF BIRTH: _____
MEDI-CAL CLIENT IDENTIFCATION NUMBER (CIN): _____
PLACEMENT AGENCY WORKER:

A. I allow the following health care providers (including mental health care providers) to share all information related to my medical history, treatment, and health (including mental health) permitted under federal and state law with persons designated as members of my Child and Family Team for purposes specified in Welfare & Institutions Code 16501(a)(4). These purposes include, but are not limited to, providing input into the development of my child or youth client plan, family plan, and/or my placement decisions.

Treating Health Care Provider Name	Type of Health Information to Share
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

B. Information that may be shared includes: past care, evaluation/tests, diagnoses, assessments, provider notes, provider orders, care records, care plan, client plan, and medicines. I understand and agree that it may also include information regarding:

☐ Sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or illness with the Human Immunodeficiency Virus (HIV) _____ Sign/date

☐ Behavioral or mental health services _____ Sign/date

☐ Alcohol and/or other drug treatment _____ Sign/date

C. I allow the following members of my Child and Family Team to receive and use information from my health care providers for the purpose of my Child and Family Team. I also authorize these members of my Child and Family Team to re-disclose this information to other listed members of my Child and Family Team to carry out the purpose of my Child and Family Team. Members of my Child and Family Team may not disclose this information to anyone outside of the Child and Family Team or for any other purpose. I understand that a new authorization form will be required if any member is added or removed from my Child and Family Team.

Child and Family Team Members:

1._____ 7._____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12._____

D. I acknowledge my right to revoke this authorization at any time. The revocation will not affect information that has already been used or disclosed.

I acknowledge that the Child and Family Team will continue to exist even if I choose not to execute this authorization. The Child and Family Team is seeking my authorization as a means of providing comprehensive support, advice, and care coordination. If I do not execute this authorization, the Child and Family Team will have less information on which to base their input, and may make different recommendations.

E. This authorization form is valid from the date I sign it until the following date: _____. I can choose to revoke it at any time. I have been given a copy of this form.

F. CHILD SIGNATURE (REQUIRED FOR YOUTH 12 AND OLDER)

(NAME OF CHILD)_____
(SIGNATURE)_____
(DATE)_____

☐ **REFUSED TO SIGN (PLEASE EXPLAIN CIRCUMSTANCES)** _____
_____
_____
_____

G. INDIVIDUAL AUTHORIZED TO CONSENT TO MEDICAL DECISIONS ON BEHALF OF CHILD (WHEN NECESSARY – SEE INSTRUCTIONS)

(NAME)_____
(SIGNATURE)_____
(RELATIONSHIP TO CHILD)_____
(DATE)_____
(TYPE OF MEDICAL DECISION(S))_____

(NAME)_____
(SIGNATURE)_____
(RELATIONSHIP TO CHILD)_____
(DATE)_____
(TYPE OF MEDICAL DECISION(S))_____

H. INDIVIDUAL AUTHORIZED TO CONSENT TO EDUCATIONAL DECISIONS ON BEHALF OF CHILD

(NAME)_____
(SIGNATURE)_____
(RELATIONSHIP TO CHILD)_____
(DATE)_____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

THIS NOTICE ACCOMPANIES A DISCLOSURE OF INFORMATION CONCERNING A CLIENT IN ALCOHOL/DRUG TREATMENT, MADE TO YOU WITH THE CONSENT OF SUCH CLIENT. THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 C.F.R. PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42

C.F.R. PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USES OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

Instructions:

A. **From Whom:** List all organizations or specific health care providers, including behavioral health providers, holding the information requested. If there are more organizations or specific health care providers than space on this form, please fill out an additional form.
   Type of Health Information: Enter the type of Information the treating providers will be disclosing. For example, general primary care records, mental health treatment records, or substance use treatment records.

B. **Requirements specific to sensitive health information:** An individual signature and date is required for disclosure of HIV, mental health, and substance use information.

C. **To Whom:** Each Member of the Child and Family team must be identified by name. Treating health care providers that are members of the child and family team may be identified generally by their organizational name (e.g. my treating providers at Kaiser) or specifically by name (e.g. Dr. Chen). If there is a change in membership of the child and family team other than a change in generally-identified treating providers, a new release is required.

D. **Acknowledgments:** This section acknowledges the youth's right to refuse or revoke consent.

E. **Terminating Date:** Select a specific date.

F. **Child signature:** Required for all youth age 12 and above. If a youth refuses to sign, information regarding care for which the youth is legally capable of providing consent may not be shared. Information regarding care outside the scope of the youth's ability to consent may still be shared with the consent of the individual authorized to consent to medical decisions on behalf of the youth.

G. **Individuals authorized to consent to medical decisions on behalf of the child or youth**: Depending on the age of the youth, the type of medical service, and the stage of the dependency case, the individual authorized to consent to medical decision on behalf of the child may differ. For example, if the foster youth has the right to personally consent to medical services, consent of a parent is not necessary and therefore the youth's written consent or a court order is required to disclose the information.

If the foster youth does not hold the exclusive right to consent to the disclosure of information, the parent or legal guardian, the caregiver, or the social worker may be authorized to consent to medical decisions depending on the type of treatment. The appropriate adult(s) with the authority to consent to the type of medical decision discussed must complete this section.

H. Individual authorized to consent to educational decisions on behalf of the child: All children under the age of 18 years must have an education rights holder. This can be a biological/adoptive parent, or a person appointed by the juvenile dependency court. The individual authorized to consent to educational decisions may have provided consent to some interventions and may have information to share with the child and family team regarding special education services and/or regional center services for the child.