NEVADA COUNTY CHILDREN'S SYSTEM OF CARE
CONSENT AND AUTHORIZATION TO DISCLOSE, EXCHANGE AND USE INFORMATION AND RECORDS

Client Name: _____ Date of Birth: _____

☐ Parent ☐ Child

I hereby authorize the identified agencies **checked** and **initialed** below to use, disclose and exchange relevant information both verbally and in writing for the purpose of collaborating, coordinating and facilitating services, placement, and treatment, as well as for claiming payment. This information may only be shared among the Team members for the limited purpose of developing and providing appropriate and coordinated services to a child or family in an effort to prevent, identify, treat and eliminate abuse of the child in a manner that assures the maximum protection of individual privacy and confidentiality rights.

Client: Please initial each checked agency.

Health and Education:
_____ ☐ Local Education Agency (LEA)/School District: _____
_____ ☐ Sierra Nevada Memorial Hospital
_____ ☐ Tahoe Truckee Forest Hospital
_____ ☐ Western Sierra Medical Clinic
_____ ☐ Well Path
_____ ☐ What's Up? Wellness Checkups
_____ ☐ Chapa-De Indian Health
_____ ☐ Primary Care Physician
_____ ☐ Sierra Care Physicians
_____ ☐ Living Well Medical Clinic
_____ ☐ Other: _____
_____ ☐ Other: _____

Nevada County Agencies:
_____ ☐ Behavioral Health
_____ ☐ Public Health, with WIC
_____ ☐ Probation
_____ ☐ Social Services
_____ ☐ Nevada County Office of Education
_____ ☐ Alta California Regional Center
_____ ☐ Nevada County Superior Court
_____ ☐ Family Court Services
_____ ☐ Other: _____
_____ ☐ Other: _____

Other:
_____ ☐ Fill in: _____
_____ ☐ Fill in: _____

Community Resources:
_____ ☐ Foster Family Agency
_____ ☐ Community Beyond Violence
_____ ☐ First 5 Nevada County
_____ ☐ Helping Hands
_____ ☐ Victor Community Support Services
_____ ☐ Granite Wellness Centers
_____ ☐ Common Goals
_____ ☐ Stanford Sierra Youth & Families
_____ ☐ Sierra Family Therapy Centers, Inc.
_____ ☐ Integrated Psychiatric Solutions
_____ ☐ Star Rose Bond
_____ ☐ Other: _____
_____ ☐ Other: _____

I authorize the release, disclosure and exchange of health information as follows:

___ ☐ Name and other personal identifying information

___ ☐ Evaluations/assessment of status and progress

___ ☐ Summaries of history, treatment and results ☐ _____

I hereby authorize the agencies **checked** above to use, disclose and exchange all information related to my substance use disorder diagnosis, information about my attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis and/or breathalyzer results, payment record, treatment plan, and discharge status. **I specifically authorize the release of the following information and records: (Minimum Necessary):**

___ ☐ Mental Health Treatment[1] ___ ☐ HIV Test Results
___ ☐ Alcohol & Drug Abuse Treatment (as outlined in the description above)
___ ☐ Educational information and records (Specify): _____

I authorize the use and/or disclosure of my individually identifiable health information as described for the purpose listed above. I understand my right to refuse to sign this authorization. Not signing this form will not affect my ability to receive services from my health care providers, but I may not be able to receive the benefits provided by the Team identified above. I understand this authorization is effective immediately and subject to revocation at any time for any reason except to the extent action has already been taken. If not revoked earlier, this authorization I expires on _____ or no later than two (2) years from the date of signature. I understand that recipients of my mental health, alcohol, and/or drug treatment records are prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

_____ _____

Signature of Client Signature of Parent/Guardian/Representative

Date Signed: _____ _____ _____

Translator (if applicable) Language

Client understands right to receive and received a copy of the authorization.

☐ Consenter declined release of information_____(staff initials) [Copy provided to client] Date declined: _____

REVOCATION

As of: _____

Month/Day/Year

I hereby revoke this Authorization _____

Signature of Client/Parent/Guardian/Representative

To Recipient Agencies: This information is protected by state and federal laws and should not be further re-disclosed to someone not included as an authorized recipient on this form without a new authorization from the client unless otherwise provided by law. If you have received alcohol and/or drug treatment program information the following admonition applies: **This information has been disclosed to you from records protected by Federal and State confidentiality rules. You are prohibited 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 applicable law. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

GENERAL

1. If this form is being used to authorize the release of psychotherapy notes, as that term is defined *by* HIPAA, a separate authorization form must be used to authorize release of any other health information. (see 45 CFR § 164.508(b)(3)(ii)
2. Verification of identity and legal authority to act as personal representative is required.
3. If authorization is for the disclosure of mental health Information for purposes other than treatment and is signed by the individual who is the subject of the information, a clinician (physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist) who is in charge of the patient must approve the disclosure and sign where indicated. (Cal. W&I Code §6328(b))
4. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR §164.508(d)(1),(e)(2)). It is recommended the client be offered a copy in all instances.