FASD PROJECT – RELEASE OF INFORMATION

Child's name: ___________________________________

Case Type: Dependency & Neglect

Authorization for Release of Information Related to Fetal Alcohol Spectrum Disorders (FASD) screening, diagnosis and treatment of a Minor or Minor Siblings

I understand that the court having jurisdiction over the above listed case(s), has ordered participation in the FASD screening and may order an FASD evaluation.

I, ____, hereby consent to communication
Parent/Guardian or authorized representative
and sharing of information regarding my child/ren
____ among the Adams County Social Services Department, the 17th Judicial District FASD Initiative staff, the Sewall Child Development Center and between them and the identified persons, agencies or entities listed below.

Persons, Entities or Agencies Authorized to Disclose and Receive Information (Check all that apply)	
❑ Judge or Magistrate having jurisdiction over the case	❑ Mother's Attorney- receive information only ❑ Father's Attorney- receive information only
❑ Guardian *Ad Litem* ❑ CASA Worker	❑ County Attorney assigned to case. ❑ Adams County Social Services Caseworker assigned to case.
❑ Juvenile/ Child's Teachers at ___________________________________ (school). ❑ Other identified Personnel at Juvenile/Child's school or school district ___________________________________ ___________________________________. ❑ Parent/Guardian/ Legal Custodian (applicable if child is in foster care and form is signed by ACSSD representative). ❑ Child's Caretakers ❑ Community Reach Center ❑ Early Childhood Connections/Child Find ❑ TriWest Group (for program evaluation) ❑ Community Center Board for Developmental Disabilities	❑ Juvenile/ Child's Therapist ___________________________________. ❑ Hospital where child was born or treated ___________________________________ (Specify hospital or hospitals) ❑ Hospital where child was treated ___________________________________ (Specify) ❑ Juvenile/Child's Physician(s) ___________________________________ ___________________________________ ___________________________________ ___________________________________ ___________________________________ ___________________________________

❑ Other (Person, agency or entity who has a duty to monitor treatment in connection with the disposition of this case or a need to know)
____

- [ ] The purpose of and need for the disclosure is to inform the person(s) and/or organizations listed above of the Child's diagnosis and needs, as well as to create a team approach to the care of the Child.

- [ ] Other Reason(s) for Disclosure

  ____

The Extent of Information to be Disclosed (Check all that apply)

- [ ] **Name and Identifying information**

- [ ] **Medical Reports/Records**
  History/Exam Data; Treatment or Testing; Immunizations; X-ray reports; Laboratory reports; Surgical Reports; Allergy Records; Prescriptions

- [ ] **Occupational, physical, speech or other testing:** records and reports of disabilities, evaluations and recommendations.

- [ ] **Child Welfare and Mental Health Information:** social worker case file, therapist case file, intake assessments, progress summaries, medical, psychological and education evaluations and consultation reports, discharge summaries, court records.

- [ ] **Education Information:** standardized test scores, grades, report cards, attendance, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), and related testing, counseling, special education, learning disability and related diagnoses, disciplinary, health, social work records reports, school counselor records.

- [ ] **Permission to test** - Early Childhood Connections screen, Child Find evaluation, or other developmental screen
- [ ] **Other (Specify)** ____

____

____

I understand that **if** the person(s) and/or organization(s) listed above are health care providers, health plans or health care clearinghouses and are "covered entities" who must follow federal privacy standards, then my child's records are protected health information, "PHI" and thus are protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164. If the information is PHI, it cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that if the person(s) and/or organization(s) listed above are not "covered entities" who must follow federal privacy standards the PHI disclosed as a result of this authorization may not be protected by HIPAA and my child's health information may be re-disclosed without my authorization.

I understand that if my child's records are protected by HIPAA, I may revoke this consent at any time in writing. However, if I have been court-ordered to participate in the FASD screening and evaluation, I may be in violation of the court's order if I revoke this consent. I am aware that if I revoke my consent, in writing, the withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that if my child is also involved in substance abuse treatment, his/her alcohol and/or drug treatment records are protected by federal law and regulations governing 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it ONLY in connection with their official duties.

I understand that if I have been court ordered to participate in the FASD program and the disclosed records are governed by 42 C.F.R. Part 2, this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of the proceeding under which I was mandated to participate.

I understand that TriWest Group will receive data only for the purpose of evaluating how the Project is doing. TriWest Group will reveal no identifying information about specific individuals to any other entity.

I understand that copies of this form may be used place of the original.

I understand that generally care providers may not condition treatment on whether I sign a consent form, but in certain limited circumstances my child may be denied treatment if I do not sign a consent form.

I understand that for the disclosure and re-disclosure of information protected by federal rules pertaining to drug/alcohol treatment, the following notice will accompany disclosed records:

PROHIBITION ON REDISCLOSURE

> This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the authorization of such client. This information has been disclosed to you from records protected by federal 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 use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this 3 page authorization form. By signing this authorization, I am confirming that it accurately reflects my intentions regarding the sharing of information about my child/ren.

Parent/Guardian Signature: ____ Date: ____________________

Relationship to Child: ____

Witness: ____ Date: ________________

Child's name: ____________________ Case No. ________________________________
Case Type: Delinquency

Authorization for Release of Information Related to Fetal Alcohol Spectrum Disorders (FASD) Diagnosis and Treatment of a Minor

I understand that the court having jurisdiction over the above listed delinquency case(s), has ordered participation in the FASD screening and following of recommendations from such screening if applicable.

I ______________________________________ hereby consent to communication and sharing of
Juvenile/Client/Patient
records and information about me among the 17th Judicial District Probation Department, the 17th Judicial District FASD Initiative staff, the Sewall Child Development Center and for these agencies to obtain and/or share information between them and the identified persons, agencies or entities listed below.

I, ____, hereby consent to communication
Parent/Guardian or authorized representative
and sharing of information regarding my child among the 17th Judicial District Probation Department, the 17th Judicial District FASD Initiative staff, the Sewall Child Development Center and between them and the identified persons, agencies or entities listed below.

Persons, Entities or Agencies Authorized to Disclose and Receive Information (Check all that apply)	
❑ Judge or Magistrate having jurisdiction over the case	❑ Prosecuting Attorney
❑ Defense Attorney ❑ Guardian Ad Litem (G.A.L.) ❑ Community Reach Center	❑ County Attorney assigned to case. ❑ Social Services Caseworker assigned to this or another case concerning the same child.
❑ Truancy Case Manager ❑ Juvenile/ Child's Teachers at __________________________________ (school). ❑ Other educational information from Juvenile/Child's school or school district ___________________________________ __________________________________. ❑ Parent/Guardian/ Legal Custodian (applicable if Juvenile/Child is 15 or older and has obtained substance abuse treatment w/out parent's consent). ❑ WorkForce ❑ Vocational Rehabilitation ❑ Community Center Board for Developmental Disabilities ❑ TriWest Group (for program evaluation)	❑ Juvenile/ Child's Therapist __________________________________. ❑ Hospital where child was born or treated _____________________________________ (specify hospital or hospitals) ❑ Juvenile/Child's Physician(s) _____________________________________ (specify) Other__________________________________ _______________________________________ _______________________________________ _______________________________________ * Some listed agencies or entities will only be providing information and will not be receiving information. This will be denoted by an asterisk * where applicable.

- ❑ Other (Person, agency or entity who has a duty to monitor treatment in connection with the disposition of this case or a need to know)

  ____

- ❑ The purpose of and need for the disclosure is to inform the person(s) and/or organizations listed above of the Juvenile/Child's diagnosis and needs, as well as to create a team approach to the care of the Juvenile/Child.

- ❑ The purpose of and need for the disclosure is to inform the person(s) and/or organizations listed above of my/my child's attendance and progress in drug/alcohol treatment.

- ❑ Other Reason(s) for Disclosure

  ____

  ____

The Extent of Information to be Disclosed (Check all that apply)

❑ **Name and Identifying information**

❑ **Drug/Alcohol Treatment Related:** Referral Information; Diagnosis Information; Clinical Progress Data; Attendance Data; Education/Termination Data; Urine Screening Results

❑ **Medical and Dental Reports/Records:** History/Exam Data; Treatment or Testing; Immunizations; X-ray reports; Laboratory reports; Surgical Reports; Allergy Records; Prescriptions

❑ **Vocational Rehabilitation:** records and reports of disabilities, evaluations and recommendations.

❑ **Child Welfare Information:** social worker case file, medical, psychological and education consultation reports, court records.

❑ **Mental Health Information:** therapist case file, intake assessments, progress summaries, evaluations of any kind, psychological and psychiatric records, and discharge summaries

❑ **Juvenile Justice Information:** law enforcement records, detention records, probation records, social and clinical studies, court records, delinquency history and status.

❑ **Education Information:** standardized test scores, grades, report cards, attendance, Individualized Education Plan (IEP) and related testing, counseling, special education, learning disability and related diagnoses, disciplinary, health, social work records reports, school counselor records.

❑ **Other (Specify)** ____

____

I understand that **if** the person(s) and/or organization(s) listed above are health care providers, health plans or health care clearinghouses and are "covered entities" who must follow federal privacy standards, then my records are protected health information, "PHI" and thus are protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164. If the information is PHI, it cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that if the person(s) and/or organization(s) listed above are not "covered entities" who

must follow federal privacy standards the PHI disclosed as a result of this authorization may not be protected by HIPAA and my health information may be re-disclosed without my authorization.

I understand that if my records are protected by HIPAA, I may revoke this consent at any time in writing. However, if I have been court-ordered to participate in the FASD screening and follow the recommendations of the screening, I may be in violation of the court's order if I revoke this consent. I am aware that if I revoke my consent, in writing, the withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I understand that if I am also involved in substance abuse treatment, my alcohol and/or drug treatment records are protected by federal law and regulations governing 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it ONLY in connection with their official duties.

I understand that if I have been court ordered to participate in the FASD program and the disclosed records are governed by 42 C.F.R. Part 2, this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or other proceeding under which I was mandated into treatment.

I understand that TriWest Group will receive data only for the purpose of evaluating how the Project is doing. TriWest Group will reveal no identifying information about specific individuals to any other entity.

I understand that copies of this form may be used in place of the original.

I understand that generally care providers may not condition treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.

I understand that for the disclosure and re-disclosure of information protected by federal rules pertaining to drug/alcohol treatment, the following notice will accompany disclosed records:

PROHIBITION ON REDISCLOSURE

> This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the authorization of such client. This information has been disclosed to you from records protected by federal 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 use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this 3 page authorization form. By signing this authorization, I am confirming that it accurately reflects my intentions regarding the sharing of information about me (juvenile/child) or about my child (parent/guardian/other).

Juvenile's/Child's Signature:____
Date:____________________

Parent/Guardian Signature: ____ Date: ____________________

Relationship to Juvenile/Child: ____

Witness: ____ Date: _______

FASD ACHIEVE

Privacy/Release of Information Agreement

I. I, ____ authorize
(Name of client – e.g. child age 0-7 – see parent signature below)

Community Assessment Referral and Education (CARE)
(Name or general designation of program making the disclosure)

to disclose to
____
(Name of person or organizations to which disclosure is to be made)

the following information (please initial applicable area):

___ Outcome of Diagnostic Screen ___ Birth Record ___ Medical Records

___ Occupational therapy records ___ School Records ___ IEP's

___ Mental Health Records including substance abuse assessments/recommendations

___ DHS Case Records ____Family History ___ Dx recommendations

___ Confirmation of appt./progress ___ Service plans ___ Case Mgmt status

The purpose of the disclosure authorized herein is: **per parent/guardian request to assist with FASD screening, diagnostic evaluation and case management/intervention services.**

II. I further authorize, ____
(Name of person or organization making disclosure)

to disclose/release information to **Community Assessment Referral and Education (CARE)**
(Name of person or organizations to which disclosure is to be made)

In regards to any or all of the boxes checked above or other listed below: _________________
____

The purpose of the disclosure authorized herein is: **per parent/guardian request to assist with FASD screening, diagnostic evaluation and case management/intervention services.**

I understand that my records are protected under the federal regulations governing 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Lack of contact (8 months), or case closure (1 year).

Date: _______________ ____
Signature of Client

____
Signature of Parent/Guardian

____
CARE representative

FASD SERVICE AGREEMENT *(Screening)*

By signing this service agreement I agree to participate in Project FASD ACHIEVE.
This project provides free screening to identify Fetal Alcohol Spectrum Disorders (FASD) and provides services for the family and the child affected with a fetal alcohol spectrum disorder. Any information shared with CARE staff will be kept private.

Services provided:

- Contact the family and set up a visit at home or office.
- Screen the child and provide family with the result.
- Refer the family to diagnostic clinic if applicable.
- Assist the family with the intake packet for the diagnostic clinic
- Schedule a follow-up appointment at the time of screen.
- Advocate for the child and family when needed.
- Provide parents with available resources.

If an appointment with the s*creene*r has to be cancelled or rescheduled please call in advance to do so. If you have any questions and/or concerns please do not hesitate to contact, Diana Laskey, B.S. at (586) 541-0033 ext. 126.

____
Parent/Guardian Signature

____
Screener

____
Date

Consent Form (Children ages birth to 7 only)
Fetal Alcohol Spectrum Disorder (FASD) – Northrop Grumman Initiative
Screening and Evaluation Process

I, ______________________________ the legal parent/guardian of ______________________________, understand the FASD Screening and Evaluation Process as explained to me by Child Guidance Center, Inc. (CGC), as follows:

- As part of a subcontract awarded to Child Guidance Center, children ages birth to 7 receiving services at CGC will be screened for Fetal Alcohol Spectrum Disorders (FASD).
- The purpose of this screening is to improve the functioning and quality of life of children and their families by diagnosing those with FASD and providing interventions based on that diagnosis.
- Facial photographs of my child will be taken and used solely for the purpose of assessment for an FASD; I understand that my child's photographs will be shared with the FASD Diagnostic Team if my child meets any of the criteria for being at-risk of having an FASD (any 2 or more of the following):
  - Face Rank of 3 or 4 on the Facial Screen
  - Sibling who has been diagnosed with an FASD
  - Confirmed prenatal alcohol exposure
  - Birth mother with confirmed drug/alcohol history at some point other than pregnancy, and the child has any of the following: growth deficit, a central nervous system or developmental abnormality, or a note in medical records indicating dysmorphia
- My child's FASD screening will be followed up with a meeting with my CGC service provider and a member of the FASD Team to discuss the results (positive or negative).
- If my child screens positive for risk of FASD, my child will be referred to the FASD Diagnostic Team for a full FASD Diagnostic Evaluation; if any information needs to be shared during this evaluation, CGC will only do so with Consent to Release/Obtain Information from the child's legal parent/guardian.
- All my child's records will be kept private in accordance with CGC's Privacy Policy.
- If my child is diagnosed with an FASD, the diagnosis will have **no** impact on me legally and will not result in a report to the Department of Children and Families; however, any information about suspected child abuse, neglect or intent to harm self or others will be reported to authorities as mandated by law.
- Participation in the screening is voluntary

By signing this form, I am agreeing that my child **will** participate in a screening and possibly a diagnostic evaluation for the presence of an FASD.

____ ____________________

Signature (parent/guardian) Date

Consent Form
The Philadelphia Fetal Alcohol Spectrum Disorders (FASD)-SDT Initiative
Screening, Assessment, and Referral Process

I, ______________________________ the legal parent/guardian of ______________________ ______, understand the FASD Screening and Assessment Process as explained to me by COMHAR, Inc., as follows:

- COMHAR, Inc., in partnership with St. Christopher's Hospital for Children and Center City Pediatrics, LLC, has been awarded a subcontract from Northrop Grumman Corporation, who has a contract from the Substance Abuse and Mental Health Services Administration;
- The purpose of this screening and assessment is to improve the functioning and quality of life of children and their families by diagnosing those with Fetal Alcohol Spectrum Disorders ("FASD") and providing interventions based on the diagnosis;
- If I sign this form, I am agreeing that my child will participate in a screening and assessment for the presence of an FASD. I should **not** sign this form until I am sure I want my child to participate and all your questions about this process have been answered;
- Photographs of my child will be taken as part of the screening and assessment process;
- My child's photographs will be used for the sole purpose of assessing him/her for a possible FASD;
- I understand that my child's photograph will be shared with St. Christopher's Hospital Children's FASD Diagnostic Team or Center City Pediatrics, LLC if my child meets any of the criteria for being at-risk of having an FASD;
- The screener will ask me to provide information about my pregnancy(ies);
- Children between the ages of Birth and 7 who meet any one of the following four criteria during screening will be referred for an FASD diagnostic assessment:

  1) Face Rank 3 or 4 when screened using the FAS Photographic Screening Tool.
  2) Sibling who previously received a diagnosis of an FASD.
  3) Confirmed prenatal alcohol exposure or drug exposure.
  4) Has a birth mother with confirmed drug or alcohol history at some point other than pregnancy, and the infant has any of the following: growth deficit, a central nervous system or developmental abnormality, or a note in medical record indicating dysmorphia.

  Exception for those 0-3 years of age: Infants that have confirmed prenatal alcohol or drug exposure, but who do not show current central nervous system abnormalities or developmental delays should be placed in a positive monitor (+ monitor) category.

- My child's FASD screening will be followed up with an assessment by a FASD staff member; my COMHAR service provider will discuss with me the findings and recommendations;

- After my child's FASD screening is assessed and if my child screens positive for an FASD, my child will be referred for a FASD Diagnostic Evaluation at St. Christopher's Hospital for Children or Center City Pediatrics, LLC;
- COMHAR, Inc. may need to share with and obtain information from my child's pediatrician, regarding my child's FASD screening. If that is necessary, I will be asked to sign a Consent to Release/Obtain Information Form;
- The privacy of my child's medical records will be protected in accordance with COMHAR's Privacy Policy, a copy of which I may receive upon request;
- Any information about suspected child abuse, neglect or intent to harm self or others will be reported to authorities as required by law;
- I may discontinue my child's participation with the FASD screening and assessment process at any time by notifying Jaimee Arndt, FASD-SDT Project Director, at 215-425-9212, extension 282;
- Participation is voluntary and refusal to participate or withdrawing from the process will not result in a loss of any services that I or my child may be receiving or will in the future receive from COMHAR;
- If I have any questions about my or my child's rights or the process in general, I may contact: Jaimee Arndt, FASD Project Director, at 215-425-9212, extension 282.

Yes, I consent to the FASD screening and assessment process:

____ ________________________

Signature (parent/guardian): Date

____ ________________________

Witness Date

Evaluation of Hennepin County Case Management Services

Consent to Use Data

Hennepin County Public Health Department Children's Services Area collects data as part of providing case management services for youth who have been through juvenile court.

What kinds of data are collected?

- Demographics (such as age and racial background)
- Juvenile court records
- Health screenings
- Records of the appointments made and whether they were kept
- School records

How is this information used?

Records from all of the youth in this program are grouped together to create a report. The report tells us:

- What kinds of services youth receive
- Which services are most helpful

Privacy

These records are kept private and stored securely. No names or identifying information are kept with the records.

Questions

If you have any questions concerns about this data collection, please contact Meghan Louis at (612) 348-2166.

Consent

You can choose to allow or not allow us to use this non-identifying information about your child in our reports. Either way, your child will still get case management services. If you choose, you may remove your child's information from the reports at any time by asking your child's case management Social Worker.

Please complete and sign the box below showing your choice:

Check one:

- ❑ I agree
- ❑ I do not agree

to allow Hennepin County Public Health Department Children's Services Area to use non-identifying data about my child, ___________________________ in reports as described above. *(print child's name)*

Signature of Parent or Guardian_____________________________ ***Date:*** _______________

Hennepin County Public Health Department Children's Services Area

Consent to Case Management Services and Voluntary Participation in FASD Program

The Hennepin County Fetal Alcohol Spectrum Disorders Program (The FASD Program) is a program provided by Hennepin County Public Health Department Children's Services Area, and is offered to youth who have been through juvenile court. Parents may voluntarily choose to have their child participate in this program.

The program screens youth for potential mental health issues and pre-natal alcohol exposure, and assists families to obtain a complete FASD diagnostic evaluation. If an FASD is found, the program will provide referrals and a variety of case management services to meet each child's specific needs.

What kinds of services are available?

- Assistance with IEP planning at school and addressing your child's individual needs
- Help with transportation to and from activities recommended by the Program
- Assistance with case planning and transition planning for your child as he/she enters adulthood
- Referrals to activities and community providers that could help your child improve his/her functioning
- Provide coordination of care for resources within Hennepin County and community providers for your child.

Please complete and sign the box below showing your choice:

Check one:

- ❑ I agree
- ❑ I do not agree

to allow my child, ________________________________

(print child's name)

to participate in the FASD Program and to receive case management services from Hennepin County Public Health Department Children's Services Area..

Signature of Parent or Guardian_____________________________ ***Date:*** _______________

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH *Authority to Release /Obtain Information*	Name: ________________________ Case #: ________________________

I hereby give my consent/permission for ____ to:
(AGENCY - ADDRESS)

PART 1: (check & complete only ONE)

A. ❑ Exchange information with ____
(AGENCY - INDIVIDUAL NAME &/OR TITLE - ADDRESS)

B. ❑ Release information to ____
(AGENCY - INDIVIDUAL NAME &/OR TITLE - ADDRESS)

C. ❑ Obtain information from____
(AGENCY - INDIVIDUAL NAME &/OR TITLE - ADDRESS)

for the specific purpose of: ❑ treatment and the coordination of services.

❑ other ____.

PART 2: (check ALL that apply)

The extent and nature of the information for disclosure, referred to in Part 1, includes the following:

- ❑ EVALUATIONS
- ❑ CASE NOTES
- ❑ SUBSTANCE ABUSE RECORDS
- ❑ PROGNOSIS AND/OR RECOMMENDATIONS
- ❑ IDENTIFYING INFORMATION
- ❑ SUMMARY OF CONTACTS
- ❑ PSYCHIATRIC RECORDS
- ❑ DIAGNOSIS
- ❑ TREATMENT PLANNING
- ❑ OTHER __________________

I understand that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent will expire upon ____________________________ ,or automatically twelve (12) months from the date
(DATE /EVENT/CONDITION)

beside the signature(s) below, and cannot be renewed without my written consent.

____
Individual Receiving Services Date

____
Authorized Representative Date
Relationship to Individual____________________________

____
Witness/Credentials Date

INDIVIDUAL RECEIVING SERVICES - IDENTIFYING DATA

Last Name	First & Middle Name	Birth Date	Social Security Number

NOTE TO PROGRAM RECEIVING THIS INFORMATION REGARDING RE-DISCLOSURE:
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE PRIVACY IS PROTECTED. State and Federal (42r CFR, Part 2) regulations prohibit you from making disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH *Consent for Services*	Name: ____________________________ Case #: ____________________________

Consent for Services

I am requesting services from this service provider. The information which I have provided as a condition of my request is true and complete to the best of my knowledge. I apply for and consent to such psychiatric, psychological, consultation counseling and/or other therapeutic services as may be recommended by the professional staff. I understand the clinical staff may discuss the services being provided to me, and that I may request the names of those involved. I further understand that my failure to comply with therapeutic recommendations of the professional staff may result in my being discharged.

I HAVE BEEN INFORMED OF, UNDERSTAND, AND HAVE RECEIVED A WRITTEN COPY OF THE ABOVE INFORMATION AND GIVE MY CONSENT TO RECEIVE SERVICES FROM THIS AGENCY:

____
Individual Receiving Services Date

____
Staff/Credentials Date

____
Authorized Representative Date

Relationship to Individual __________

MISSISSIPPI DEPARTMENT OF MENTAL HEALTH *Rights of Individuals Receiving Services*	Name: ______________________________ Case #: ______________________________

I, ______________________________ entered ______________________________
(Name) **(Provider or Service)**
on ____________________ and have been informed of the following:
(Intake/Admission date)

1. My options within the program and of other services available.
2. The program's rules and regulations.
3. The responsibility of the program to refer me to another agency if this program becomes unable to serve me or meet my needs.
4. My right to refuse treatment and withdraw from this program at any time.
5. My right not to be subjected to corporal punishment or unethical treatment which includes my right to be free from all forms of abuse or harassment and my right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
6. My right to voice my opinions, recommendations and to file a written grievance which will result in program review and response without retribution.
7. My right to be informed of and provided a copy of the local procedure for filing a grievance/complaint at the local level or with the DMH Office of Constituency Services.
8. My right to privacy in respect to facility visitors in day programs and residential programs as much as physically possible.
9. My right regarding the program's nondiscrimination policies related to HIV infection and AIDS.
10. My right to be treated with consideration, respect, and full recognition of my dignity and individual worth.
11. My right to have reasonable access to the clergy and advocates and have access to legal counsel at all times.
12. My right to review my records, except when restricted by law.
13. My right to fully participate in and receive a copy of my comprehensive treatment/habilitation/service plan/plan of care. This includes: 1) having the right to make decisions regarding my care, being involved in my care planning, and treatment and being able to request or refuse treatment; 2) having access to information in my clinical records within a reasonable time frame (5 days) or having the reason for not having them communicated to me; and, 3) having the right to be informed about any hazardous side effects of medication prescribed by staff medical personnel.
14. My right to retain all Constitutional rights, except when restricted by due process and resulting court order.
15. My right to have a family member or representative of my choice notified should I be admitted to a hospital.
16. My right to receive care in a safe setting.
17. My right to privacy regarding my personal information involving receiving services as well as the compilation, storage, and dissemination of my individual case records in accordance with standards outlined by the Department of Mental Health and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable.

Additionally, rights for individuals in residential living arrangements:

18. My right to be provided a means of communicating with persons outside the program.
19. My right to have visitation by close relatives and/or significant others during reasonable hours unless clinically contraindicated and documented in my case record.
20. My right to be provided with safe storage, accessibility, and accountability of my funds.

21. My right to be permitted to send/receive mail without hindrance unless clinically contraindicated and documented in my case record.
22. My right to be permitted to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in my case record.

I have been informed of, understand, and have received a written copy of the above information.

____

Individual Receiving Services **Date** **Authorized Representative** **Date**

____

Staff/Credentials **Date** **Relationship to Individual**

For use if the legal custody is with parent or guardian

White Earth Indian Child Welfare
PO Box 358
White Earth, MN 56591
Phone: 218-983-4647
Fax: 218-983-3712

I,____, as the parent or legal guardian of

the minor child/ren____

hereby grant permission to White Earth Indian Child Welfare to release, to the White Earth

FASD program the following information (please initial applicable area):

___ Results of diagnostic assessment ___Confirmation of appt./progress

___ Service plans ___ Case Mgmt status

Other ____

______It has been explained to me and I understand that the purpose of the disclosure is to assist with FASD screening, diagnostic evaluation and case management/intervention services.

I understand that my records are protected under the federal regulations governing 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **Lack of contact (8 months), or case closure (1 year).**

Date: _______________ ____
Signature of Parent or guardian

Date_______________ ____
ICW representative

For use if the legal custody is with White Earth Indian Child Welfare

White Earth Indian Child Welfare
PO Box 358
White Earth, MN 56591
Phone: 218-983-4647
Fax: 218-983-3712

I,____, a duly authorized representative

of White Earth Indian Child Welfare, as legal custodian of the minor

child/ren____

hereby grant permission to White Earth Indian Child Welfare to release, to the White Earth

FASD program the following information (please initial applicable area):

___ Results of diagnostic assessment ___Confirmation of appt./progress

___ Service plans ___ Case Mgmt status

Other ____

______It has been explained to me and I understand that the purpose of the disclosure is to assist with FASD screening, diagnostic evaluation and case management/intervention services.

I understand that my records are protected under the federal regulations governing 42 CFR Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45CFR Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **Lack of contact (8 months), or case closure (1 year).**

Date_______________ ____

ICW representative

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
ELVENTH DIVISION

DEPARTMENT OF HEALTH AND HUMAN SERVICES PLAINTIFF

V. CASE NO:

[*Alleged Offender(s) Name (s) is here*]

MINOR CHILDREN:

[*All minor children involved in the case and/or currently in foster care are here*] DEFENDENTS

PROBABLE CAUSE ORDER AS TO JUVENILE(S), [*Juveniles name(s) are here*]

On this [*date of Probable Cause hearing is here*], the above entitled cause of action is presented to the Court for probable cause hearing upon a petition filed by the Arkansas Department of Human Services, Honorable, Melinda R. Gilbert presiding. Present before the Court were the persons checked, as follows:

[ ] ***Mother:***
[ ] ***Mother's Counsel:***
[ ] ***Attorney Ad Litem***
[ ] ***DHS Counsel***
[ ] ***Father:***
[ ] ***Putative Father:***
[ ] ***Juvenile(s):***
[ ] ***FASD Family Service Worker:***
[ ] ***DCFS Assessor***
[ ] ***DCFS Family Service Worker***

From the testimony, exhibits, statements of the parties and counsel, the record herein, and other things and matters presented, the Court, noting the best interests, welfare, health and safety and appropriate statutory placement alternatives, does hereby ***FIND, ORDER, ADJUDGE AND DECREE:***

1. The court has jurisdiction of the parties and the subject matter with due notice of the probable cause hearing for the Juvenile(s) [*name of juvenile(s) is here*], having been provided to the parties, as follows: [*normally list, in this space, who received "due notice of the probable cause hearing" relative to the family and case*]
2. That the following checked items were identified, considered and entered into evidence: [items and/or documents filed as evidence]
3. That the mother and father have or do not have membership in or is a descent from an Indian tribe and if notice to ICWA is required.
4. That based upon the parent's testimony and the completed affidavit of indignecy, the Court hereby makes the following findings regarding court appointed counsel, as checked below: [*whether mother and/or father, who the children were removed from is here and the counsel who has been appointed to represent the parent(s)]*
5. On, [date that the 72-hour hold was taken on juvenile(s) is here], a seventy-two (72) hour hold was taken on the Juvenile(s) [*name of juvenile(s) is here*]. The Court finds that the first contact of the Arkansas Department of Human Services arose during the emergency where immediate action was necessary and in the best interests to protect the health, safety and welfare of the Juveniles and where preventative services could not be provided, therefore the Arkansas Department of Human Services is deemed to have made reasonable efforts to prevent or eliminate the need for removing the juveniles from the juvenile's home. Base upon these efforts, and Emergency Ex-Parte Order was entered on [*date is here*] placing custody of the above named juvenile with the Arkansas Department of Human Services and scheduled probable cause hearing.
6. In accordance with Arkansas Code Annotated, Section 9-27-315 and based upon a preponderance of the evidence, probable cause is found and is substantiated by the emergency conditions necessitation removal of the juvenile [*name(s) o f juvenile(s) is here*] from the custody of the mother that existed at the time the hold was exercised over the juvenile(s) and continues to exist.

7. The findings and orders of the Court supporting probable cause are, as follows: [*list of factors supporting probable cause is here]*

8. That it is in the best interest of the juveniles to remain and be placed in DHS care and custody and it is contrary to the health, safety and welfare of the minors to return to mother and the placement in DHS care and custody is necessary to protect health, safety and welfare of the juveniles.

9. The court authorizes the Department or its agents when acting as custodian of the minors to enter consent to specific medical, dental or mental health treatment and procedure as required in the opinion of a duly authorized or licensed physician, dentist, surgeon, or psychologist, whether or not such care is rendered on a emergency basis, and the court consents to such care.

10. Based upon the agreement of the parties, the family and juveniles are in need of services form DHS, the Family Services ordered and the family is ordered to cooperate, participate, complete and follow all directives and recommendations for the items checked, as follows:

Juveniles

[ ] Foster care placement/services
[ ] Therapeutic Foster Care Placement
[ ] visitation services
[ ] Clothing assistance
[ ] Emergency Shelter
[ ] Parenting classes
[ ] Transportation services
[ ] Day care services
[ ] Comprehensive Health Assessment
[ ] Medication assessment
[ ] Dental services
[ ] Ophthalmology services
[ ] Fetal Alcohol Syndrome Assessment
[ ] Anger management counseling
[ ] Counseling, individual
[ ] Counseling, family
[ ] Forensic psychological evaluation
[ ] Residential treatment
[ ] Random drug screens
[ ] Drug and alcohol assessment
[ ] Educational Assistance services
[ ] Refrain from illegal activities
[ ] Submit of paternity DNA swab testing

Mother

[ ] Provide complete medical history for juvenile(s)
[ ] Parenting Classes
[ ] anger Management classes
[ ] Forensic psych eval & follow recommendations
[ ] Counseling, individual and follow recommendations
[ ] Counseling, family, follow recommendations
[ ] Random drug screens
[ ] Remain drug free
[ ] Provide vital information for the FASD Assessment
[ ] Drug and Alcohol assessment and follow recommendations
[ ] Residential treatment drugs/alcohol And follow recommendations

Father

[*same options for father is listed here*]

[ ] AA/NA attendance____x week
[ ] Provide sign-in sheets for AA/NA
[ ] Take any prescribed medication
[ ] Homemaker services
[ ] Intensive in-home services
[ ] Maintain stable and suitable housing
[ ] Maintain stable employment
[ ] Demonstrate ability to financially support self
[ ] Pay child support for juvenile(s)
[ ] Attend Staffings
[ ] Comply with terms of Case Plan
[ ] Cooperate with the Department
[ ] Make contact with Department
[ ] Attend visitations with juvenile(s)
[ ] Demonstrate improved parenting
[ ] Maintain reliable transportation or seek assistance from DHS
[ ] Submit to paternity DNA swab testing
[ ] Complete affidavit of financial means
[ ] Refrain from criminal activity

11. The Department of Human Services is ordered to assist, complete and provide the items checked, as follows: [*checklist of items to be completed by DHS is here*]
12. Prior orders of this Court which do not conflict with this Order shall remain in full force and effect.
13. **Jurisdiction of this cause is continued with an adjudication hearing scheduled for [*date and time is here*] and any additional time is hereby waived for good cause.**

IT IS SO ORDERED.

____
MELINDA R. GILBERT
11TH DIVISON CIRCUIT JUDGE

Dated: ___________________________

ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name: ______________________ **Client ID #:** ______________________
Mailing Address: C/O DHHS/DCFS **Date of Birth:** ______________________
______________________ **Case Head:** ______________________

I, Cherisse Cashaw FASD FSW Specialist ______________________ hereby authorize
(Client or Personal Representative)

______________________ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: C/O Cherisse Cashaw FASD FSW Specialist
P.O. Box 2620
Little Rock, AR 72203

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s): information will be used for Fetal Alcohol Spectrum Disorder Sreening

Specific information to be disclosed: Birth records
"All Medical Records" includes any and all written information you may have concerning my health care and any illness or injury I may have suffered, including, but not limited to, medical history, consultations, prescriptions, treatment, medical evaluations, x-rays, results of tests, and copies of hospital or medical records pertaining to me.

I understand that this authorization will expire on the following date, event or condition: 1 year from date signed

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the 42 CFR Part 2, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, sexually transmitted diseases, alcohol abuse, drug abuse, psychological or psychiatric conditions, genetic testing, family planning, or womens, infant, & children (WIC) this disclosure will include that information.

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization. A copy of this authorization shall be as binding as the original.

______________________ ______________________ ______________________
(Signature of Client) *(Date)* *(Witness-If Required)*

______________________ ______________________ Agent for DHHS/DCFS
(Signature of Personal Representative) *(Date)* *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on ______________________ ______________________
(Date) *(Signature of Staff)*

ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of ______________________________
(Name of Client)

signed by ______________________________ on ______________________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded effective ______________ I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

______________________	__________	______________________	__________
(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*

______________________	__________	______________________
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

The Department of Health & Human Services is in compliance with Titles VI and VII of the Civil Rights Act. This letter is available in other languages and alternate formats.