



# Albemarle/Charlottesville Children's Services Act Consent to Exchange Confidential Information



*I understand that my family will be participating in an interagency service planning process under the provisions of the Children's Services Act (CSA) VA §2.2-5200. CSA seeks to provide high quality, child centered, family focused, cost effective, community-based services to youth with specialized needs and their families. By signing this form, I am allowing agencies to exchange certain information about my child and family so that they may work together to provide or coordinate these services or benefits. All information about children and families obtained by team members to perform their responsibilities is confidential.*

<b>PRINTED NAME OF CHILD CLIENT(S):</b>		
<b>PRINTED NAME OF PERSON CONSENTING</b> for themselves, or on behalf of or in addition to child client		
<b>ROLE OF CONSENTING PERSON:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian/Custodian <input type="checkbox"/> Authorized Representative		
<b>EMAIL OF CONSENTING PERSON:</b> <i>enter text.</i>		
<b>CHILD CLIENT'S BIRTHDATE</b>	<b>CLIENT'S LEGAL ADDRESS:</b>	
<b><i>I authorize the following organizations or individual(s) to exchange</i></b>		
-Child Specific Team (CST)	-Community Attention	-Albemarle/Charlottesville Juvenile Domestic Relations Court
-Family Assessment and Planning Team (FAPT)	-Blue Ridge Health District (BRHD)	-VA Office for Children's Services (OCS/CSA)
-Community Policy Management Team (CPMT)	-Albemarle/Charlottesville Public Schools	-Dept. Behavioral Health Development Svcs. (DBHDS)
-Region Ten Community Services Board (CSB)	-16 <sup>th</sup> District Court Service Unit (CSU)	-Other: <u>enter text.</u>
-Albemarle/Charlottesville Department of Social Services (DSS)		
<input type="checkbox"/> <b><u>ALL</u> information below</b> <b>OR</b> <input type="checkbox"/> <b><u>ONLY</u> the information checked below</b>		
<input type="checkbox"/> Medical Health Records	<input type="checkbox"/> Juvenile Justice Records	<input type="checkbox"/> Education Records
<input type="checkbox"/> Mental Health Records	<input type="checkbox"/> Financial Information	<input type="checkbox"/> Social Services Records
	<input type="checkbox"/> Federal/State Benefits Records	<input type="checkbox"/> Other Treatment status/verbal treatment reports/referral information
<input type="checkbox"/> Should we relocate to another jurisdiction in Virginia, information will be transferred to new locality	<b>Client Initials:</b>	
<input type="checkbox"/> Substance Use Treatment Record (42CFR Part2)	<b>Client Initials:</b>	
-For Services, Treatment, Payment, and Healthcare Operations; and -For responding to local, state, or federal audits or reporting requirements; and -The following purpose (must be specific): <i>Discussing, planning, and decisions regarding services and treatment.</i>		

**Redisclosure:**

- If these records are protected by Federal Substance Use Confidentiality Regulations (42 CFR Part 2), I understand that substance use disorder information disclosed based on this authorization is prohibited from further disclosure, and this information may not be used to criminally investigate or prosecute substance use disorder patients, unless otherwise permitted by 42 CFR Part 2.
- If these records are not protected by 42 CFR Part 2, I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal HIPAA Regulations.

**I understand that:**

- I may cancel this authorization at any time by notifying the referring agency except to the extent that an entity has already acted on it.
- I have the right to know what information about me has been shared and with whom it was shared.
- The CSB and HD may not condition their treatment, payment, or eligibility for benefits on whether I sign this authorization.
- Virginia law requires that to receive CSA funding for services, referring agencies disclose services, treatment, and/or education records to the FAPT for a full and informed assessment, and Virginia law requires the provision of certain information to OCS and DBHDS.
- Entities disclosing substance use disorder information based on this authorization are to share the minimum necessary amount of information to accomplish the purpose of the disclosure.
- This authorization is given of my own free will. I have been given a copy of this authorization or a copy has been placed in my file.

**SIGNATURE OF PERSON CONSENTING:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**CHILD'S SIGNATURE (if applicable) \*:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Name of Person Explaining Form: \_\_\_\_\_

**This authorization is in effect from the date of signature above until the child reaches the age of 18, OR until the end of the client's participation in CSA services, whichever comes first; OR until \_\_\_\_\_**  
 (Date)

\*If child consented to their own treatment under VA §54.1-2969(E), including substance use, mental health, infectious disease, family planning, child must also sign to release their own records. Child must sign own form when reaching age 18.

\*\*All capitalized terms on form are as defined by HIPAA, 42 CFR Part 2, and the Children's Services Act.