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.

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| **CHILD’S INFORMATION:** | | | |
| **PRINTED NAME OF CHILD CLIENT** *Click or tap here to enter text.* | | | **DATE OF BIRTH:** enter DOB. |
| **CHILD CLIENT’S LEGAL ADDRESS:** Click or tap here to enter text. | | | |
| **CONSENTING INDIVIDUAL’S INFORMATION:** | | | |
| **PRINTED NAME OF PERSON CONSENTING** for themselves, or on behalf of or in addition to child client  enter name of person consenting. | | | |
| **I am consenting in the following role for the child client listed above:** Self  Parent  Power of Attorney  Guardian/Custodian  Authorized Representative | | | |
| **ADDRESS:** Click or tap here to enter text. | | **EMAIL** enter text. | |
| **I authorize the following organizations or individual(s) to exchange** | | | |
| -Multidisciplinary Service Planning Teams (FRM/FPM) | -Fairfax Co. Department of Family Svcs. | | -Fairfax Juvenile Domestic Relations District Court |
| -Family Assessment and Planning Team (FAPT) | -Fairfax Co. Health Department (HD) | | -VA Office for Children’s Services (OCS/CSA) |
| -Community Policy Management Team (CPMT) | -Fairfax Co. Public Schools | | -Dept. Behavioral Health Development Svcs. (DBHDS) |
| -Fairfax-Falls Church Community Services Board (CSB) | -Falls Church City Public Schools | | -CSA in locality where the client relocates (if app.) |
| -Other **(please include name of providers):** enter text. | | | |
| **ALL information below OR**   **ONLY the information checked below** | | | |
| Substance Use Treatment Record (42CFR Part2) | Juvenile Justice Records | | Education Records |
| Medical Health Records | Financial Information | | Social Services Records |
| Mental Health Records | Federal/State Benefits Records | | Other enter text. |
|  | | | |
| -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): enter text. | | | |

**Redisclosure:**

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| * 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.

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| ***SIGNATURE OF PERSON CONSENTING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***CHILD’S SIGNATURE (if applicable)*** *\*:* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  Name of Person Explaining Form: \_enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­ | |
| **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. | |

**Instructions for Completing the Consent to Exchange Confidential Information**

This form is required for any youth, family member, and/or legal guardian/custodian who is requesting CSA services. It needs to be completed accurately and completely. Case managers must explain the form to obtain informed consent.

* **Full Printed Name of Child Client**: Print the name of the child client.
* **DOB**: enter child’s date of birth.
* **Full Printed Name of Person Consenting**: Print the name of the parent, legal guardian/custodian, or healthcare power of attorney who is authorized to consent to exchange information for the youth or for themselves. If a youth has consented to their own treatment for a venereal or infectious disease, birth control or pregnancy, substance use disorder, or mental illness or emotional disturbance under Va. Code § 54.1-2969(E), then the youth must consent to release of their related treatment records. CSB records may require the youth’s consent.
* **Email**: Print the email address of the parent or guardian. CSA may use the email address to communicate with parent/guardian via welcome letter or to solicit general information via surveys.
* **Other service providers or agencies**: Any other provider or person who is not listed in the paragraph that lists the agencies that will be exchanging information should be included on this line.
* **Check the information to be exchanged**: The person giving consent is to check that they consent to exchange either all information or only the information checked**.** If they check the latter, they must also check the relevant boxes below. The case manager will need to explain that not checking certain information may prohibit the family from receiving CSA services in that service area.
* **Other Information**: This line can be used to include any information that needs to be exchanged that is not included in the above box.
* **Purposes:** Any additional purposes for exchanging the information should be listed here.
* **Signature**:The parent or legal guardian should sign and date on this line.
* **Child’s Signature:** If a youth has consented to their own treatment for a venereal or infectious disease, birth control or pregnancy, substance use disorder, mental illness or emotional disturbance, and the records to be released relate to that treatment, the youth must also sign and date on this line.
* **Person explaining form**: The case manager’s name goes here.
* **Expiration date**: Unless the client does not agree for the authorization to be valid until the child turns 18, or until the end of the client’s participation in CSA services, there is no need to add an expiration date or event.

**FAQs**

* **Is my child required to sign?** If the child is seeking services for themselves, then the child’s signature is required. If the parent is seeking services on behalf of the child, then the child’s signature is preferred, but not required.
* **How do I rescind my consent?** The consenting person will need to send a written request to [DFSCSA@fairfaxcounty.gov](mailto:DFSCSA@fairfaxcounty.gov) to void this consent. *\*Please note: Rescinding your consent will automatically end all CSA funding.*
* **At what age should a child sign their own consent?** A child can sign at any age; however, we encourage any child 13 years old or older to sign the consent. Anyone ***18 or older*** ***MUST*** sign their own consent, unless guardianship paperwork is provided.
* **If a parent consents, but a child refuse to sign, can we still get services?** Yes, if the parent is initiating services on behalf of the child.

Page 2 is for information only

Submit page 1 only