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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PARENT/GUARDIAN’S FULL NAME:** *Click or tap here to enter text.* | | | | | **DATE OF BIRTH:** *enter a date.* |
| **LEGAL ADDRESS:** Click or tap here to enter text. | | **EMAIL:** Click or tap here to enter text. | | | |
| **FULL NAME(S) AND DATE OF BIRTH(S) OF CHILDREN RECEIVING CSA SERVICES:**  **\*Please note this does NOT constitute release of information for the children below; this information is for CSA reference only.** | | | | | |
| NAME: Click or tap here to enter text. | | | | DOB: enter a date. | |
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|  | | | | | |
| **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):** Click or tap here to enter text. | | | | | |
| **ALL information below OR**   **ONLY the information checked below** | | | | | |
| Substance Use Treatment Record (42CFR Part2) | Criminal Records | | Other: Click or tap here to enter text. | | |
| Medical Health Records | Financial Information | |  | | |
| Mental Health Records | Federal/State Benefits Records | |  | | |
|  | | | | | |
| -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): *Click or tap here to enter text.* | | | | | |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**This authorization is in effect from the date of signature** **above until the end of the client’s participation in CSA services,**

***OR* until** enter a date. (Date)

Name of Person Explaining From: *Click or tap here to enter text.*

\*\*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 parent/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 Name of Parent/Guardian**: Print the name of the parent/guardian requesting CSA services.
* **DOB**: enter parent/guardian’s date of birth.
* **Legal Address**: Enter the parent/guardian’s legal address.
* **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.
* **Name(s)/DOB(s) of Children Receiving CSA Services**: Enter the name and date of birth of children under your care who are receiving CSA services.
* **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.
* **Person explaining form**: The case manager’s name goes here.
* **Expiration date**: The consent will be valid until CSA services are discontinued unless and end date is entered.

***\*NOTE:*** *You may rescind your consent by providing a written request to* [*DFSCSA@fairfaxcounty.gov*](mailto:DFSCSA@fairfaxcounty.gov) *to void this consent. Rescinding your consent will automatically end all CSA funding.*

Page 2 is for information only

Submit page 1 only