AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
FOSTER CARE ASSESSMENT PROGRAM (FCAP)

I authorize the use, disclosure and exchange of protected health information between **foster parents, school personnel, and treatment providers** and the staff of the **Foster Care Assessment Program, a Department of Child & Family Services (DCFS) contractor**, as provided in WA State RCW 26.44.030(7) and as outlined below.

Protected health information may be disclosed by: **foster parents, school personnel, and treatment providers.**
Protected health information may be disclosed to and exchanged between: **social workers, treatment providers and pediatricians** of the **Foster Care Assessment Program (FCAP)**.

Regarding: _____ Birth Date: ___/__/___
Patient/Client (Minor Child)

PURPOSE OF DISCLOSURE

The purpose of disclosure is to assist the FCAP and DCFS in planning for my children, and/or assisting in meeting the health needs and developing a permanency plan for this child.

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

EXPIRATION OF AUTHORIZATION

This authorization expires on (date) **OR** when the following event occurs: **FCAP case closure**

(State when you want to stop disclosing information according to this authorization). If this authorization is for the purpose of disclosing information other than payment information to an employer or financial institution, the authorization will be effective for no more than 90 days from the date signed or, if you specify, a period less that 90 days.

ORAL AND WRITTEN INFORMATION TO BE DISCLOSED

I SPECIFICALLY CONSENT TO THE RELEASE OF THE INFORMATION CHECKED BELOW:

ALL RECORDS
SUMMARY OF MEDICAL HISTORY/ TREATMENT
LABORATORY/ DIAGNOSTIC TESTS
PSYCHOLOGICAL TESTING

PATHOLOGY SPECIMEN(S)/ SLIDE(S)
DISCHARGE SUMMARY
CONSULTATION
EKG REPORT
PATHOLOGY REPORT(S)

RADIOLOGY RECORDS
RADIOLOGY FILMS
EEG REPORT
OPERATIVE REPORT

OTHER: _____

I understand that the information in my health record may include sensitive information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse

I understand that information related to drug/alcohol abuse evaluation and treatment is protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent except as otherwise provided for in the regulations.

COURT ORDERED RELEASES OF INFORMATION

This release of information was was not court ordered; if court ordered; Case Name: _____;
Legal Number: _____; Date of Court Order; __/__/__; Judge/Commissioner:

I UNDERSTAND THE TERMS OF THIS AUTHORIZATION AND BY SIGNATURE AGREE TO IT.

SIGNATURE: _____
DATE: ____/___/____
client/ patient; or parent; or legal next of kin; or
legal guardian of the client/patient.

SIGNATURE: _____
DATE: ____/___/____
client/ patient; or parent; or legal next of kin; or
legal guardian of the client/patient.