

**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 Children, Youth and Families (DCYF) 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 and administrative staff 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 DCYF in planning, and/or assisting in meeting the health needs and developing a permanency plan for this child/youth.

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 than 90 days.

ORAL AND WRITTEN INFORMATION TO BE DISCLOSED

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

- | | | |
|--|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> PATHOLOGY | <input type="checkbox"/> RADIOLOGY RECORDS |
| <input type="checkbox"/> SUMMARY OF MEDICAL HISTORY/ TREATMENT | <input type="checkbox"/> SPECIMEN(S)/ SLIDE(S) | <input type="checkbox"/> RADIOLOGY FILMS |
| <input type="checkbox"/> LABORATORY/ DIAGNOSTIC TESTS | <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> EEG REPORT |
| <input type="checkbox"/> PSYCHOLOGICAL TESTING | <input type="checkbox"/> CONSULTATION | <input type="checkbox"/> SUBSTANCE ABUSE TREATMENT RECORDS |
| | <input type="checkbox"/> EKG REPORT | <input type="checkbox"/> MENTAL HEALTH TREATMENT RECORDS |
| | <input type="checkbox"/> PATHOLOGY REPORT(S) | |

OTHER: _____

I understand that the information in my health record may include sensitive information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), 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. I authorize the release of sensitive information described here.

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
- parent
- legal next of kin
- legal guardian of the client/patient.

SIGNATURE: _____
DATE: ___/___/___

- client/ patient
- parent
- legal next of kin
- legal guardian of the client/patient.