

Allegheny County Department of Human Services One Smithfield Street Pittsburgh, PA 15222 Phone: 1-800-862-6783 Fax: 412-350-5891

# Child/ Adolescent Interagency Meeting Authorization

## Authorization for Use Or Disclosure of Health and other Sensitive Information

I hereby authorize the participants and organizations indicated on the Participant Roster to use/disclose the following Protected Health Information and other confidential information about me (Identifying Information Below):

Date of Birth: S	Social Security #:
Address:	
nformation to be used, disclosed.	
<ul> <li>Education Records</li> <li>Report Cards and Attendance Records</li> <li>Immunizations</li> <li>Scholastic / Achievement Testing</li> <li>Observations by teacher or guidance counselor</li> <li>Psychological / Psychiatric Testing</li> </ul>	<ul> <li>Medical Records (In – Patient)</li> <li>Birth Records</li> <li>Hospitalization Records</li> <li>Dental Records</li> <li>Medical Records (Out-Patient)</li> <li>Hospital Records</li> <li>Immunization Records</li> <li>Dental Records</li> <li>Dental Records</li> <li>Control Records</li> </ul>
Mental Health / Drug & Alcohol / HIV	CASA
<ul> <li>Intake Assessment and Social History</li> <li>Developmental/Psychological/ Psychiatric Evaluations and Recommendations</li> <li>AIDS or related HIV testing</li> <li>Progress Notes</li> <li>Confirmation of Attendance/ Visit Dates</li> </ul>	□ Other: Specify:
<ul> <li>Social Services Information</li> <li>Release and Acquisition of Information Consent</li> </ul>	

#### Purpose

This information is to be disclosed to the participants and organizations indicated on the Participants Roster for the purpose of developing a comprehensive individual service plan and providing appropriate services to the child and family. Disclosures may also include follow-up discussions and communication made by participants to implement the service plan and to coordinate care.

### **Rights and Option to Revoke**

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, a written request may be sent to the entity where the authorization was provided. Unless otherwise revoked, this authorization will expire on the date that the child or family disenrolls from all services provided by the participating agencies and their representatives. The participating organizations, their programs, services, employees, officers, representatives, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand that the Allegheny County Department of Human Services and participating organizations will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

I understand that I may inspect or copy my personal health information and may also choose not to sign this authorization.

I am entitled to a copy of this completed authorization.

I understand that not all attending participants on the Participants Roster must comply with federal privacy regulations and consequently the information disclosed pursuant to this authorization is subject to redisclosure by the recipient and may be no longer protected by federal privacy regulations.

If this authorization is to be signed by a personal representative, please describe the authority to act for the individual.

Signature of Client or Personal Representative

Date

Signature of Witness

Date

#### **Participant Roster**

The participants and organizations below acknowledge by signature below that they will obtain and share confidential information on the specified individual and will not disclose this information without the proper consent of the parent/guardian and/or child as permitted by state and federal laws and regulations. This information will be used for the purpose of developing a comprehensive individual service plan and providing appropriate services to the child and family. It should not be used for purposes other than those specified without the expressed permission of the child and family.

Name:	Name:
а: 	Signature:
Titler	Title:
A	Agency:
Addroses	Address:
City/State/Zip:	Phone:
Phone:	Fax:
Fax:	
Email:	
Name:	Name:
Signature:	Signature:
Title:	Title
Agapau	Agency:
A 11	Address
City/State/Zip: Phone:	Phone:
Phone:	Fax:
	Email:
Email:	
Name:	Name:
Signature:	Signature:
Title:	Title:
	Agency:
Agency:Address:	Address:
City/State/Zip:	Phone:
Phone:	Fax:
Fax:	Email:
Email:	
	Name:
Name:	Signature:
Signature:	Title:
Title:	—— Agency:
Agency:	
Address:	City/State/Zin
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Phone:	—— Fax:
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