

Confidentiality and Consent Forms

Although the layout of the confidentiality forms are unique to each state, there is little variation across the states with regard to content and use. Every state requires a client to sign a release of information allowing mental health staff to share information with the welfare agency and other service providers. Clients are also notified about the types of information that are kept confidential. In some states, clients are required to sign a statement declaring that they are voluntarily participating in mental health services. In each state, licensed mental health professional (or mental health staff under the supervision of a licensed mental health professional) complete the forms. The forms used in the study states include:

- Utah:** Disclosure/Verification Form and Authorization for Release of Information Form
- Tennessee:** Consent for Release of Confidential Information Form and Informed Consent Form
- Oregon:** Authorization for Release of Information Form
- Florida:** Consent for the Release of Confidential Information Form.

MENTAL HEALTH SERVICES DISCLOSURE / VERIFICATION FORM

The purpose of this interview is to provide the customer with the opportunity to:

- ➔ Discuss any issues which fall within the scope of Mental Health Services and to identify potential barriers to employment or training
- ➔ Identify treatment strategies, agreed upon by both customer and Licensed Clinical Therapist (LCT), to minimize or alleviate these barriers
- ➔ Assist the customer in participating in services offered by DWS

It is further understood that any information disclosed to the assigned LCT will be made available to the assigned DWS employment counselor, his/her supervisor and any other agencies or individuals as indicated on the *Authorization for Release of Information* forms. Further, the customer has the right to terminate activities associated with Mental Health Services by marking the appropriate statement below.

In accordance with Utah State law, I understand that the LCT is required by law to report the following information to the appropriate authorities:

1. Child abuse or neglect
2. Abuse, neglect or exploitation of an elder or disabled adult
3. Therapists Duty to Warn (intent to harm self or others)
4. Communicable diseases

Having read and understood the information provided above, I, _____, acknowledge that I have been fully informed by _____ as to the purpose of my having been referred to Mental Health Services, the purposes for which any information that I choose to disclose will be used, to whom that information will be given and under what conditions. Having gained this understanding:

_____ I voluntarily agree to participate in this process.

_____ I elect not to participate further in this process.

Signature of Customer

Date

Licensed Clinical Therapist (LCT)

Date

MENTAL HEALTH SERVICES AUTHORIZATION FOR RELEASE OF INFORMATION

Customer: _____ DOB: _____ PACMIS #: _____

I understand that my records are protected under state and federal regulations as well as professional codes of ethics governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I further understand that my records are 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 unless otherwise provided for in the regulations. This release includes but is not limited to information regarding alcohol and/or substance abuse history, treatment and progress of treatment. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as designated below.

I, hereby, authorize _____, to release information to and receive information from those entities listed below and initialed by me, which may be needed for the ongoing development and implementation of my individualized employment plan. I understand that this information is confidential and will only be made available to those individuals within these agencies who have been identified to assist me with this process.

<input checked="" type="checkbox"/>	<i>AGENCY</i>	<i>PROVIDER</i>	<i>CUSTOMER'S INITIALS</i>
	DWS Employment Counselor		
	DWS Supervisor		

I grant this permission for the six month period from _____ to _____.

Signature of Customer

Date

Licensed Clinical Therapist (LCT)

Date



Family Services Counseling Consent for Release of Confidential Information

1. I, _____, date of birth _____, SSN _____
authorize the Family Services Counseling Program to disclose to:

2. π _____
the following information: _____
_____ for the purpose of _____

3. I furthermore consent to the release of information by _____
to the Family Services Counseling program pertaining to:

- | | |
|-----------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Dates of Hospitalization |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Court/Police Documents and Reports |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Mental Status |
| <input type="checkbox"/> Psychological Test Results | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Drug and Alcohol Treatment | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Records | <input type="checkbox"/> Crisis Intervention Reports |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Educational Records | <input type="checkbox"/> Educational Tests and Reports |
| <input type="checkbox"/> Psychosocial Report | <input type="checkbox"/> Lab Reports |

Other (specify) _____

for the purpose of :

- Conducting and formulating a comprehensive screening and assessment
- Determining service(s) most appropriate for customer needs
- Facilitating the provision or coordination of services
- Other (specify) _____

4. I understand no information may be redisclosed to any other individual or agency unless by my written consent.

5. I understand that I may revoke this consent at any time by written request, except to the extent that action has already been taken, and that unless such action is taken, this consent will automatically expire on _____

Customer Signature _____ Date _____

FSC Signature _____ Date _____

This notice accompanies a disclosure of information made to you with the consent of the customer. This information has been disclosed to you from records protected by Federal and/or State confidentiality rules. The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal and/or State rules and regulations. A general authorization for the release of medical or other information may not be sufficient for this purpose.



Family Services Counseling Informed Consent

I _____, date of birth _____, do hereby acknowledge that the following Department of Human Services Family Services Counseling program information has been explained to me and that I understand and willingly give my consent to be screened, assessed, and, if appropriate, provided and/or referred for additional services.

Because counseling services may be offered as a part of the Family Services Counseling program, the confidentiality of the records maintained by this program is protected by Federal and/or State law and regulations. Confidentiality may be limited by the following conditions:

1. I understand that I must give my written consent to disclose or release information to/from another person or agency when such information is deemed beneficial to my case. An additional consent form will be signed.
2. I understand that incidents or suspicion of physical and/or sexual abuse or neglect of a child will be reported, by law to the appropriate agency.
3. I understand that incidents or direct threats of harm to self or others may be reported to the appropriate agency or persons.
4. I understand that information may be disclosed as a result of a court order or subpoena.
5. I agree that confidential case information may be disclosed to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
6. I understand that my counselor may report to DHS my active/failed participation in counseling when the PRP mandates counseling in the plan.
7. I agree that my counselor may report to DHS Families First eligibility criteria not reported by me.
8. Permission is given to see _____ (minor) for assessment, counseling and/or referral. I understand that I have the right to consultation regarding progress. I agree to cooperate with the counselor in an effort to facilitate services. By my signature below, I certify that I am the parent, legal guardian, or custodian of said minor child.

By my signature I agree to the above and hereby certify that the above information has been discussed with me.

Signature _____ Date _____
(Customer)

Signature _____ Date _____
(FSC Counselor)



Authorization for Release of Information

To Our Clients: We can serve you better if we are able to work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to release information about your situation.

This material is available in alternative formats including Braille, computer disk, large print and oral presentation, for persons that are visually impaired and meet the guidelines for the Americans with Disabilities Act.

Section A	Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth
	Child Legal Name Last	First	MI	Date of Birth

I authorize the following record holders; (individuals, schools, employer, or agencies)

Section B	CLIENT INITIAL	RECORD HOLDERS	HOW MUCH AND WHAT KIND OF RECORDS	MUTUAL EXCHANGE YES/NO

To release to: (If releasing to a team, list agency members on back of form)

Section C	CLIENT INITIAL	TO	PURPOSE	EXPIRATION DATE OR EVENT

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. Initial one: _____ Yes _____ No

I can cancel this authorization for release at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Section D	<input checked="" type="checkbox"/> Full Legal Signature or Mark of Client Date				
	<input type="checkbox"/> Client <input type="checkbox"/> Spouse	<input type="checkbox"/> Parent <input type="checkbox"/> Adult Child	<input type="checkbox"/> Guardian <input type="checkbox"/> Other Family	<input type="checkbox"/> Legal Custodian <input type="checkbox"/> Attorney	<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Caseworker
	<input checked="" type="checkbox"/> Full Signature of Worker Date			Initiating Agency	

To those receiving information under this authorization:

This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document.

To release to:

Section C	CLIENT INITIAL	TO	PURPOSE	EXPIRATION DATE OR EVENT

Instructions

1. The worker should fill out this form for the client. Be sure the client understands it before signing. Encourage the client to ask questions about the form and what it allows.
2. **Cannot read/Cannot write:** A client may substitute a signature with making a mark or by asking someone to sign on his/her behalf.
3. This is a **Voluntary Form**. However, clients should be given accurate information on how the refusal to allow the release of information may adversely affect eligibility determination or coordination of services. If the client decides not to sign, consider referring the individual or family to a single service which may be able to help them without an exchange of information.
4. **Guardianship/Custody.** If the signer is a guardian, a copy of the guardianship paper must be attached when the request is sent. Similarly, if an agency has custody, and their representative signs, the custody order should be included.
5. **Duration.** The authorization is valid for one year unless otherwise specified.
6. **Family Records.** This release covers information about the person signing the form, minor children and information about the family he/she supplied for the record. It would not cover information supplied by other adult family members unless they also sign a release.
7. **Children.** Minors can consent to medical treatment at age 15; mental, emotional or chemical dependency treatment, at age 14. They may sign their own permission for release of information forms needed for such treatment.
8. **Revocation.** If the person later cancels this authorization, write "revoked" and the method and date of revocation boldly across the form. Date and initial it, and keep in the file. Federal regulations do not allow us to require that the revocation be in writing.
9. **Mail Requests.** If this form is being used to request information by mail, be specific about what you need. If you have a series of questions, use a cover letter. The more clear you are in your request, the more likely you are to receive a prompt and accurate response. Do not ask for information you do not need.
10. **Photocopying.** Keep the original in the file and send copies to other agencies. The person making the photocopies should sign each copy at the bottom of the first page certifying it as a true copy. The agency receiving the authorization should reject it if there is not an original signature by the person who made the copy.

Special Attention:

11. **Redisclosure.** Information received under this authorization should not be redisclosed to any party not identified on this form without specific written consent. Criminal penalties may apply to illegal disclosure. Federal regulations (42 CFR part 2) prohibit you from making any further disclosures of Alcohol and Drug information and state rules OAR 333-12-270, ORS 433.045 prohibit further disclosure of HIV/AIDS information, and statutes ORS 659.700-659.720 and OAR 333-24-0500 through 0560 prohibit further disclosure of Genetics information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.
12. **HIV/AIDS.** A general release is not sufficient. Identification of a specific individual, agency or facility is required including 3rd party payers, a specific purpose for the release and a specific time period are necessary.
13. **Genetics.** A general release is not sufficient for genetic test results but is sufficient for general historical information. OAR 333-024-0550 (Appendix 2) requires use of a specific genetic release form for disclosure or redisclosure. Provision of the specified form to the tested individual is required.

**Temporary Assistance for Needy Families (TANF)
Substance Abuse and Mental Health Program
Consent for the Release of Confidential Information**

Name

Social Security Number

I authorize my Public Assistance Specialist or designee, Regional Workforce Board (RWB) designee, or FSP representative (if applicable) _____, Substance Abuse and Mental Health (SAMH) Service Provider _____, and TANF SAMH Specialist or designee who are working on my behalf, to receive and disclose the initialed information regarding my:

- _____ 1. employment efforts and progress
- _____ 2. screening and testing results
- _____ 3. full assessment recommendations
- _____ 4. treatment progress and discharge

The release of further confidential information and/or release to any other party **will require my additional written consent.** Please identify specific additional information to be released if applicable.

The purpose for the release of information is: _____

The additional person(s) with whom this information will be exchanged: _____

I understand that my records are protected under Federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and Chapter 397, Florida Statutes. I also understand that I may take back my consent at any time or otherwise it will automatically expire in six months from the date signed below.

Signature of the TCA Applicant

Date

Signature of Witness

Date

For Official Use: This information has been disclosed to you from records protected by Federal protected confidentiality rules (42 CFR Part 2) and Chapter 397, Florida Statutes. The federal and state rules prohibit you from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2 and Chapters 394 and 397, F.S. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal and state rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient.

Original – SAMH Service Provider