Authorization to Disclose Protected Health Information Between Multidisciplinary

Plans of Safe Care Team Members

Parent/Caregiver: _____ DOB:_____

Parent/Caregiver: _____ DOB:_____

Child: _____ DOB: _____

By signing this authorization, I hereby voluntarily permit the use or disclosure of Protected Health Information (PHI) pertaining to me, my child, my health, or my health care (including paper, oral, and electronic interchange) by and to the following individuals or organizations (check all that apply) for purposes of Plans of Safe Care Core Team meetings only:

COLUMBIA COUNTY PLAN OF SAFE CARE CORE TEAM MEMBERS

□ Columbia County Children and Youth Services
□ CMSU Early Intervention
□ CMSU Drug and Alcohol
□ CMSU Mental Health
□ Columbia County Family Center
□ Geisinger Medical Center staff
□ Geisinger Medication Assisted Treatment Program

OTHER IDENTIFIED PROVIDERS (please specify provider name)

□ Home Visitation Program: _____

□ Substance Use Disorder Treatment Provider: _____

□ Mental Health Provider: _____

□ Managed Care of Private Insurance Provider: _____

□ Hospital or Medical Provider: _____

□ Hospital or Medical Provider: _____

□ Other Service Provider: _____

OTHER IDENTIFIED SUPPORTS:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Type of information to be disclosed for parent and child is as follows:

____ Admission/Discharge	_____ Medications	_____ Laboratory Results	_____ X-Ray/Imaging
____ Psychiatric Evaluation	_____ Psychiatric Treatment	_____ D&A Evaluation	_____ D&A Treatment
____ Diagnosis/Prognosis	_____ HIV/AIDS Status	_____ Progress Notes	_____ Pregnancy Records

Information at the Plans of Safe Care Core Team meeting will be held in strict confidence and used for the purpose of assessment of needs, planning and coordination of services, and evaluation of progress and effectiveness of services. Any re-disclosure of your protected health information is prohibited without your authorization.

The Plans of Safe Care Core Coordinator will assist the family in meeting the goals of the established plan.

Changes to the Plan of Safe Care can be made as deemed necessary.

This authorization will expire in one (1) year subsequent to the date of signature.

You have the right to revoke this authorization at any time and may do so by contacting your assigned lead in writing. You have the right to revoke this authorization except to the extent that any action has already been taken based upon this authorization. If we have already used or disclosed your protected health information before receiving your revocation, you understand that we cannot take back those uses or disclosures.

_____	_____	_____
Printed Name of Parent/Caregiver	Signature of Parent/Caregiver	Date

_____	_____	_____
Printed Name of Parent/Caregiver	Signature of Parent/Caregiver	Date

For those individuals physically unable to sign this document: I, _____, am physically unable to sign this authorization. My verbal understanding of this document is hereby witnessed by the individual whose signature appears below.

_____	_____	_____
Witness Printed Name	Witness Signature	Date