

**INFORMED CONSENT AND RELEASE OF INFORMATION AND RECORDS**

Name \_\_\_\_\_ SSN \_\_\_\_\_

I understand to help my family and me get the services we need the Department for Community Based Services (DCBS) and other agency staff persons may need to share information and records in order to provide or verify eligibility for these services. By signing this form, I give DCBS staff or staff of another agency, authorized to act on behalf of DCBS, permission to get any information needed to see if I am eligible for any assistance program. I also give permission for DCBS and the following agencies or persons listed below to share information and records with one another about services, benefits or treatment provided to me and my family:

Name of Agency or Individual	Name of Agency or Individual	Name of Agency or Individual

My consent includes the following information and records (please put your initials beside each checked item that you consent to):

- |   |  |
|---|--|
| <input type="checkbox"/> Medical and Physical Health Records (not HIV or AIDS)  |  |
| <input type="checkbox"/> Behavioral Health and Psychiatric Records (not Drug or Alcohol Abuse Patient Records or Psychotherapy Notes) |  |
| <input type="checkbox"/> Psychosocial History   | <input checked="" type="checkbox"/> Housing Records                        |
| <input type="checkbox"/> Psychological Test Results   | <input checked="" type="checkbox"/> Residential Records                    |
| <input checked="" type="checkbox"/> Child Care Records  | <input checked="" type="checkbox"/> Child Support/ Spousal Support Records |
| <input type="checkbox"/> Student School Records   | <input checked="" type="checkbox"/> SNAP Records                           |
| <input type="checkbox"/> Long-term Facility and Alternate Care Records  | <input checked="" type="checkbox"/> K-TAP Records                          |
| <input type="checkbox"/> Statement of Legal Status and Custody  | <input checked="" type="checkbox"/> Medicaid Records                       |
| <input type="checkbox"/> Home Care and Home Health Records  | <input type="checkbox"/> Child Protective Services Records                 |
| <input type="checkbox"/> Spouse Abuse and Rape Crisis Center Records  | <input type="checkbox"/> Adult Protective Services Records                 |
| <input type="checkbox"/> Senior Program Provider Records  | <input checked="" type="checkbox"/> Financial Records                      |
| <input type="checkbox"/> Homeless Shelter Records   | <input checked="" type="checkbox"/> Employment Records                     |
| <input type="checkbox"/> Court Records  | <input type="checkbox"/> Other _____                                       |

This consent applies to the following members of my family for whom I have the legal authority to consent:

Member Name	SSN	Relationship	Member Name	SSN	Relationship
	- -			- -	
	- -			- -	
	- -			- -	
	- -			- -	

I understand that:

- This authorization will be in effect for a period of 12 months (not to exceed 12 months) from the signature date.
- I may revoke this consent at any time in writing unless action has already been taken based on my consent.
- DCBS will not condition treatment, payment, enrollment or eligibility for benefits on receipt of this form. Signing this form is voluntary, but failing to sign it, or revoking it before the necessary information is obtained, could prevent an accurate or timely response and could result in denial or loss of benefits.
- Information may be disclosed with the other DCBS Divisions to assist in obtaining the requested services.
- Information disclosed to DCBS may no longer be protected by the health information privacy provisions of 45 CFR Parts 160 and 164 pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- Information may be disclosed by DCBS without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2 or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.
- I have received a copy of this form. I may also request a copy of the information retained with it.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Client  Parent  Legal Guardian  Other (specify) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Client  Parent  Spouse  Legal Guardian  Other (specify) \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

DCBS worker (specify program area) \_\_\_\_\_  Other agency staff (specify) **Child Care Assistance Program**