

Confidential Health Information Consent Agreement or Withdrawal

PRINT NAME OF CLIENT

CLIENT'S DATE OF BIRTH

You have been referred to the Fostering Well-Being (FWB) program so that our program can help you and others involved in your care understand your health needs. While in out-of-home placement, it is important that your health care providers and others involved in your care be able to communicate with each other to coordinate your health care. At times, your health records may be on a computer system or in writing and may include information about:

- Family planning services like birth control and abortion;
- Sexually Transmitted Infections (STI), infections you can get from having sex, previously known as "Sexually Transmitted Diseases (STD)," and/or HIV/AIDS; and/or
- Mental Health medications and services;
- Chemical Dependency services

Since these types of health information are private, the partners who have your health information cannot give this health information to other people unless you agree, or Washington State law says they can give the information to other people.

If you do not sign this form, you will still be able to get services from the FWB program. **All youth over the age of 13 referred to our program will be asked if they want to sign this form, whether or not the type of health information in this form applies to you.**

By signing this consent, I agree that the people I have identified on this form have permission to view my private confidential medical information. They may consult with one another to help me manage my health care. My confidential medical information may include records about illnesses or injuries that I have now or had in the past. Records may include test results (such as X-rays and blood tests), medicines I take now or took in the past, and records from visits to hospitals, provider offices or other clinics and/or facilities.

I understand I can withdraw my consent at any time by signing this form and giving it to my Social Worker or to the FWB program. This will not affect any information already shared.

Section 1:

I AGREE to allow the FWB program to receive and share my health information marked below with my health and mental health care providers including my Department of Children, Youth, and Families (DCYF) Social Worker and/or Tribal Social Worker, my current Caregiver, and Biological Parent(s):

- All my client records, including, but not limited to, Medical, Reproductive Health (i.e. birth control, pregnancy, and abortion), HIV/ AIDS and STD/STI test results, diagnosis or treatment records (RCW 70.02.220), Mental Health records (RCW 70.02.230), and Chemical Dependency (CD) records (42 CFR Part 2).

OR (if Section 1 is not completed, please complete both parts of Section 2 below)

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Section 2: (Sections 2A and 2B must be completed)

2A. I AGREE to allow the FWB program to receive and share information about my health marked below with only those Provider / Partners marked below:

- HIV/AIDS and STD/STI test results, diagnosis, or treatment (RCW 70.02.220)
- Reproductive Health (family planning services such as birth control and abortion)
- Mental Health records (RCW 70.02.230)
- Chemical Dependency (CD) records (42 CFR Part 2)

2B. Providers / Partners that the FWB program can share your records with (check all that apply):

- Medical Providers Current DCYF and/or Tribal Social Worker
- Reproductive Health Providers Current Caregiver / Foster Parent / Kinship Caregiver
- Mental Health Providers
- Biological Parent(s) (list first and last names):
- Other (list):

I also AGREE that the partners listed on this form may share my health information with each other and cannot share it with anyone who is not listed on this form. I can change my mind and take back my consent at any time by **checking the box below (using a new DSHS 10-489), signing it,** and giving it to my Social Worker or to the FWB program. This will not affect any information already shared. Initials: _____

Unless previously withdrawn by me, the specific information above is valid until I am no longer in foster care, or until _____.
EXPIRATION DATE

I withdraw my consent. Please complete the following signature section.

CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE

DATE

PRINT NAME OF LEGAL REPRESENTATIVE

RELATIONSHIP OF LEGAL REPRESENTATIVE TO CLIENT

Notice to Recipients: This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any 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 42 CFR, Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.