CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Washtenaw County Children's Services

Use this form to give or take away your consent to share information about your child's:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form is Needed

When your child receives health care, their health care provider and health plan keep records about their health and the services they receive. This information becomes part of their medical record. Under state and federal laws, your child's health care provider and health plan do not need your consent to share most types of your health information to treat your child, coordinate their care, or get paid for their care. But they may need consent to share your child's behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Section 5.
- Sign the completed form, then return it to Washtenaw County Children's Services. They can make a copy for you.

Section 1: About Your Child

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Child's Information and How They Can Share It

Sharing Information Between Individuals and Organizations

Let us know who can see and share your child's behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

Agency	**Contact Person**	**Phone Number**	**Initials**
ISD:			
School:			
DHHS:			
Court:			
Primary Care Physician:			
Therapist:			
Psychiatrist:			
Other:			

Section 3: What Information You Want to Share

Choose one option:

☐ Share **all** my behavioral health and substance use disorder records.

☐ Share **only** the types of behavioral health and substance use disorder records listed below.

☐ Psychiatric Assessment
☐ Psychological Assessment
☐ Medical Information
☐ Medication Information
☐ Substance Abuse Assessment
☐ School Reports
☐ Progress Reports
☐ Treatment Concerns
☐ Treatment and Discharge Plans

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my child's behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, my child can still get treatment. But, without this form, Washtenaw County Children's Services may not have all the information needed to treat my child.
- My child's records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for their needs.
- My child's records may be shared with the people or organizations as stated in Section 2.
- I can remove my consent to share my child's behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language that I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my child's treatment.)
  Date, event, or condition:_____

State your relationship to the person giving consent and then sign and date below:

☐ Self

☐ Parent (Print Name)_____

☐ Guardian (Print Name)_____

☐ Authorized Representative (Print Name)_____

Signature	Date
Witness Signature	Date

TAKE AWAY YOUR CONSENT
Complete Section 5 if you no longer want to share your child's records listed above in Section 3.

Section 5: Who Can No Longer See Your Child's Information
I no longer want to share my records with those listed in Section 2. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person giving consent and then sign and date below:

☐ Self

☐ Parent (Print Name)_____

☐ Guardian (Print Name)_____

☐ Authorized Representative (Print Name)_____

Signature	Date
Witness Signature	Date

FOR WASHTENAW COUNTY CHILDREN'S SERVICES USE ONLY

Verbal Withdrawal of Consent
☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.
☐ Individual listed above in Section 1.

☐ Parent (Print Name)_____

☐ Guardian (Print Name)_____

☐ Authorized Representative (Print Name)_____

Signature of Person Who Received the Verbal Withdrawal	Print Name	Date

Form Copy
☐ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.