JV-226(TC) Authorization to Release Health and Mental Health Information

Fill in court name and street address:

Tribal Court of:

This form authorizes the release of the child's health and/or mental health records to the child welfare agency to ensure that the child receives appropriate and effective services. It also allows the agency to carry out its case management responsibilities; to monitor treatment, health-care operations, and billing and payment; and to inform the court of the child's medical and/or mental health needs. This form complies with the Health Insurance Portability and Accountability Act (HIPAA), Confidentiality of Medical Information Act (CMIA), and Lanterman-Petris-Short (LPS) Act.

Fill in child's name and date of birth:

Child's Name:

Date of Birth:

Case Number:

The parent, legal guardian, or Indian custodian may only complete items ①, ②, ③, ⑥, ⑦, ⑧, and ⑨.

The child may only complete items ①, ②, ④, ⑤, ⑥, ⑦, and ⑧.

① I am the
- a. ☐ Parent
- b. ☐ Legal guardian
- c. ☐ Indian custodian
- d. ☐ Child, and I am eligible to consent

② I give the following child welfare agencies and individuals permission to release health information about ☐ me ☐ the child _____

_____

_____

_____

_____

③ I am the parent, legal guardian, or Indian custodian and I authorize release of the following medical information. Mental health information contained in the medical file may not be released.

☐ I understand that I may **refuse** to sign this form. I understand that the child cannot be denied treatment just because I choose not to sign. *(Check all that apply):*

- a. ☐ Diagnoses
- b. ☐ Medical histories
- c. ☐ Medications
- d. ☐ Immunizations
- e. ☐ Lab reports
- f. ☐ X-ray reports
- g. ☐ None
- h. ☐ _____

Child's name: _____ **Case Number:**

4 *If the child is between 12 and 18 years old, the child may authorize release of the following information.*

☐ I discussed the contents of this form with my attorney before deciding whether or not to sign this form. I understand that I may **refuse** to sign this form. I understand that I cannot be denied treatment just because I choose not to sign.

I am the child and I authorize the following information to be disclosed *(check all that apply):*

a. ☐ HIV information, including test results
b. ☐ Mental health diagnoses
c. ☐ Outpatient mental health treatment or counseling records
d. ☐ Records regarding sexually transmitted diseases
e. ☐ Records regarding infectious, contagious, or communicable disease if law or regulation requires the disease or condition to be reported to the local health officer
f. ☐ None

5 *Only the child, regardless of his or her age, may authorize release of the following information.*

☐ I discussed the contents of this form with my attorney before deciding whether or not to sign this form. I understand that I may **refuse** to sign this form. I understand that I cannot be denied treatment just because I choose not to sign.

I am the child, and I authorize the following information to be disclosed *(check all that apply):*

a. ☐ Pregnancy records
b. ☐ Reproductive health records
c. ☐ Sexual assault treatment records, if the child consented to this treatment
d. ☐ None

6 I give permission to release ☐ my ☐ the child's health information specified by the checked boxes in items 3, 4, and 5 and to discuss them with *(name of child welfare agency):* _____.

7 I understand that the child welfare agency may share or be required to share ☐ my ☐ the child's health and/or mental health information with certain persons or agencies for purposes of treatment, health-care operations, billing and payment, or as otherwise required by law, without having to ask for my permission.

I understand that if this health and mental health information is disclosed to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

Child's name: _____ **Case Number:**

8 a. ☐ I request a copy of this form.
b. ☐ I am the child and understand that I do not have to give this form to my parent or legal guardian.
c. ☐ I do not want a copy of this form.
d. ☐ I request a copy of the records that will be released.

9 I understand that I may revoke this authorization by writing to *(name and address of person to whom revocation should be directed):* _____

Once this person receives my written request, this authorization will be revoked, but only to the extent that the authorization has not already been relied upon to release health information.

10 This authorization automatically ends one year from date of signature.

11 This form is not intended to abrogate the rights of court-appointed counsel for the child to access records pursuant to Welfare and Institutions Code section 317(f) or court order.

Date:

_____ ▶ _____
(TYPE OR PRINT NAME OF PARENT/LEGAL GUARDIAN) (SIGNATURE)

_____ ▶ _____
(TYPE OR PRINT NAME OF CHILD) (SIGNATURE)

IMPORTANT: PLEASE READ

The health-care provider may refuse to release the records if he or she determines that access to the child's records would have a detrimental effect on the provider's professional relationship with the child or the child's physical safety or psychological well-being.