**AUTHORIZATION FOR RELEASE OF INFORMATION TO**

**CHILD ADVOCACY CENTER**

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Name of Client (First, Middle, Last) Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (number and street, city, state, ZIP code)

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Date of Birth

I hereby authorize the Indiana Department of Child Services (DCS) to **release and share** confidential information, including but not limited to, evaluation records, reports, and other information as determined by DCS (collectively referred to as “confidential information”), to

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(Name of Child Advocacy Center (“CAC”))

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(Address of organization)

The purpose of this release isto allow the CAC to utilize the above described confidential information in its Multi-Disciplinary Team (“MDT”) meetings and case reviews. MDT members work together to conduct interviews and make team decisions about investigation, treatment, and management of cases. MDT members may include law enforcement, DCS personnel, prosecutors, medical and mental health professionals, guardians ad litem, Court Appointed Special Advocates, and/or other providers of services to children and families.

The CAC understands that it will be held to the same confidentiality provisions as DCS is required to maintain by statute and the CAC shall not use the confidential information received under this release outside of the purposes of the MDT. Furthermore, the CAC will ensure it has on file signed confidentiality forms for all CAC personnel and MDT members who participate in any MDT that involves the client’s confidential information.

**Health Records**

**I understand protected health information may be included in the information DCS releases to the CAC. I hereby voluntarily authorize the release, use, and disclosure of the protected health information, including health records, mental health records, and substance abuse/addiction records.**

* **I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including, but not limited to, information regarding treatment and related services for alcohol and/or substance abuse/addiction, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.**
* **NOTE TO CAC: Alcohol & Drug Prohibition of Re-disclosure Notice: If the record(s) contain drug and/or alcohol information, then this information has been disclosed to the CAC from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit the CAC 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. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**
* Client understands that the CAC authorized to receive the confidential information (except Alcohol and Drug as described above) may not be governed by HIPAA regulations. Information released to such persons or entities may be subject to re-disclosure without client’s knowledge.

Revocation: This release is subject to revocation at any time (in a writing signed by the client or his/her legally authorized representative), except to the extent that action has been taken in reliance on the release. The CAC shall immediately notify DCS of any such revocation.

Expiration: If not previously revoked, this release will be valid for a period of **three (3) years** from the date of signature. Any use of the confidential information beyond three (3) years will require the execution of a new release.

Upon revocation or expiration of the release, the CAC shall destroy the confidential information in a secure manner.

I understand that I may refuse to sign this release and that my refusal will not affect my ability to obtain services.

**I hereby state that I have read and fully understand the above statements as they apply to me and may refuse authorization to release any/all information. I am entitled to a copy of this release.**

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Signature of Client or Client’s Personal Representative Date of Signature (month, day, year)

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Printed Name of Client or Client’s Personal Representative Description of Personal Representative’s Authority to Act for

Client

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Personal Representative’s Address, City, State, Zip

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Personal Representative’s Primary Telephone Number