

**Authorization to Use &/or Disclose Educational, Protected Health &/or Corrections Information For Wraparound Oregon**

**1. I authorize the following provider(s) to use and/or disclose educational, protected health, &/or corrections information regarding my child.**

\_\_\_\_\_  
(Child/Youth's Name)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Family/Guardian)

**Wraparound Oregon Intake Committee**  
\_\_\_\_\_  
(Referral Committee Name)

**Name and address of provider/referral agency authorized to:**

- Send/disclose protected education, health and/or corrections information
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Name and address of WO contact authorized to:**

- Receive/use protected health, social service &/or corrections information
  - Receive/use protected educational information
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**2. Representatives of the following organizations are members of the WO Intake Committee:**

- Multnomah Education Service District, WO staff member;
- Multnomah Early Intervention/Early Childhood Special Education staff member
- Morrison Center
- Family Advisory Council Member
- Multnomah County Department of Community Justice

- Department of Human Services/Child Welfare staff member
- Multnomah County Mental Health staff member
- WO Care Coordinator Supervisors from Albertina Kerr Center
- Parent Partner/Facilitator
- Portland State University Regional Research Institute
- Oregon Youth Authority
- Other (specified): \_\_\_\_\_

**3. I understand that this information will be used for the following purposes :**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Determining eligibility for Wraparound Oregon</li> <li><input type="checkbox"/> On-going case planning after eligibility determination</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> No information will be shared by the Referral Committee that has not received signed consent for release and discussion</li> </ul> |
|---|--|

**4. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Physician's Eligibility Statement</li> <li><input type="checkbox"/> Health Assessment Statement</li> <li><input type="checkbox"/> Prenatal information</li> <li><input type="checkbox"/> IFSP/IEP document</li> <li><input type="checkbox"/> MCO Community Justice Records</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Communicable disease(s)</li> <li><input type="checkbox"/> Progress notes</li> <li><input type="checkbox"/> Clinic records</li> <li><input type="checkbox"/> Additional issues facing the family</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Psychological evaluations and findings</li> <li><input type="checkbox"/> Social work reports, including plan for child</li> <li><input type="checkbox"/> Childs current living situation</li> <li><input type="checkbox"/> OYA Case Plan</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
|---|--|--|

**5. By *initialing* the spaces below, I authorize the use/disclosure of the following, if identified specifically by referral source:**

- \_\_\_ Mental health related information requested: \_\_\_\_\_
- \_\_\_ Early childhood educational Information requested: \_\_\_\_\_
- \_\_\_ DHS/Child Welfare care plan information: \_\_\_\_\_
- \_\_\_ Additional medical/health information: \_\_\_\_\_
- \_\_\_ Additional social services information: \_\_\_\_\_
- \_\_\_ OYA Case Plan: \_\_\_\_\_
- \_\_\_ Community Justice Case Plan: \_\_\_\_\_

**6. I understand that:**

- a. This authorization is voluntary and I may refuse to sign it without affecting my child's health care or eligibility for current services.
- b. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- c. I may revoke this authorization at any time by notifying \_\_\_\_\_ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.
- d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
- e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals, the disclosed information may no longer be protected by federal privacy regulations.

**7. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.**

\_\_\_\_\_  
(Signature of Parent, Legal Guardian, Student/Child)      (Relationship)      (Date) (Expires – 1 year from date of signature)

**Purpose of form:**

- So that referring agencies could release information to the WO Intake Committee.
- This form is used when there is a need to obtain consent from a parent, legal guardian or student/child to authorize the referring agency to:
  - Send/disclose protected health information, Child Welfare, educational information, Juvenile Justice and/or Oregon Youth Authority Information.

**Directions for completing form:****Box 1. Required.**

- Enter the student/child's full legal name including middle name;
- Enter child's date of birth;
- Enter the name and address of the referring agency, who will send requested protected health, Child Welfare, educational &/or corrections information;
- Enter the name and address for the WO Intake Committee receiving the requested protected health, Child Welfare, educational &/or corrections information

**Box 2. Required:**

- Mark all the boxes of the participating agencies on the WO Intake Committee. For an agency that is not represented in the list, check the "other" box and specify the additional agency, organization or individual.

**Box 3. Required:**

- Mark both of the boxes that apply regarding which specific medical, Child Welfare, educational, &/or corrections records are being requested. .

**Box 4.**

- Mark the boxes approving the release/transfer of the information necessary for consideration by the WO Intake committee.

**Box 5.** Required only if the form is being used to communicate additional information.

**Box 6 & 7. Required:**

- This box contains information relating to the parent's, guardian's, or child's rights in giving authorization including the right to refuse to sign, the right to request a copy after signing, the right to inspect the information to be used and/or disclosed, and the right to revoke the authorization. Information is given that clarifies that when requested information is sent, the laws that protect that information may no longer apply since the receiving agency may not be bound by the same laws as the sending agency.
- In item c., identify who will receive the potential revocation. The statement clarifies that if an action has already been taken, for example, protected health information has already been sent, then the revocation for that specific information is not valid. However, the agency may voluntarily return the information received after the revocation has been signed and submitted.
- Parent, legal guardian, or student/child must sign for the authorization to be valid. If parent or guardian, the relationship to the child must be indicated. The date of the signature must be entered.
- The authorization is only valid for the purposes checked or stated in the form.