Adams County Integrated Children's Services
COMMON INFORMATION RELEASE FORM for PRE-INTAKE SCREENING

I hereby authorize the following county offices and their respective representatives,

❑ Adams County Children & Youth	❑ York/Adams Mental Retardation Program
❑ York/Adams Mental Health Program	❑ York/Adams Drug and Alcohol Program
❑ York/Adams Early Intervention	❑ Community Care Behavioral Health (CCBH)

to obtain and share with each other limited screening information *(i*dentifying demographic information, family composition, school information, reason for call and, client and family risk factors – *strike through what pieces not to release)* gathered from:

_____

(Name) *(Birth Date)*

_____

(Address) *(Zipcode)* *(School District)*

for the purpose of providing services to: _____.
(Name)

In addition, I hereby authorize the screener to disclose and share the limited screening information with the following organizations and person(s) for the purpose of making referrals or case conferencing connections *(please select all that apply):*

❑ School district (name)	❑ York/Adams CASSP
❑ York/Adams Health Choices	❑ Family Group Decision Making
❑ Adams/Hanover Counseling Services	❑ Adams County Juvenile Probation Office
❑ LIU #12	***Please list all others below:***
❑ Family Physician (name)	❑
❑ Survivors, Inc.	❑
❑ Psychiatrist/Psychologists	❑
❑ Hospital (name)	❑
❑ Vocational skills assessment	❑

I understand that this release is valid for a period of no longer than 12 months from the date of signature and may be revoked by notifying any of the above organizations or person(s) in writing or verbally with witnesses. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect these actions.

_____ *(Initials of Signer)*

The following information is relative to the services requested and information to be shared. Please review each section carefully. Once reviewed, please initial the section to signify you have read and understand the information contained therein.

Mental Health Services
In accordance with Pennsylvania Regulations, this information may be disclosed to on your behalf from records whose confidentiality is protected by State Law. State regulations limit recipient's rights to make any further disclosure of this information without the prior written consent of the person to whom it pertains.

_____ *(Initials of Signer)*

I understand that some of the organizations I have authorized to receive information may not be of a health plan or health care provider in nature and that the information may be re-disclosed and no longer protected by federal privacy regulations. However, certain protected records such as drug and /or alcohol abuse treatment or referrals for treatment, HIV information and mental health services may not be re-disclosed per Pennsylvania State Laws and Regulations (as noted above) and/or Federal Confidentiality rules (HIPAA).

_____ *(Initials of Signer)*

Drug and Alcohol Services
This information is being disclosed from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the 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.

_____ *(Initials of Signer)*

I understand that treatment, payment, enrollment or eligibility for benefits and services are not subject to signing this release. However, I choose to sign this release voluntarily to receive coordination of services. I have read all pages of this form carefully and understand the information contained within.

Signature		***Date***
Signature of Minor (age 14 and above)		***Date***
Signature of Parent or Guardian	***(Relationship)***	***Date***
Signature of Witness		***Date***
****** Signature of Witness***		***Date***

*** For those county entities able to obtain a Verbal ROI, this section requires signature from two witnesses who can attest to the fact that the consumer gave his or her verbal permission to release information from the screening for the sole purpose listed above, and that the consumer understands the nature of this release and has freely given his/her consent. The following should be signed by the consumer upon the first visit to the agency following the consent of release date.

I hereby acknowledge, confirm, and ratify my release of information previously given verbally, on

_____.
Date of Original Verbal Release

Signature	***Date***