

## Confidential Health Information Consent Agreement

You have been referred to the Fostering Well-Being Care Coordination Unit (FWB CCU) so that our unit can help other people involved in your care understand your health needs. While in foster care, it is important that your health care providers and other people involved in your care be able to talk to each other about your health care. At times, your health record may include information about:

- Family planning services like birth control and abortion;
- HIV/AIDS; and/or
- Sexually-transmitted diseases (diseases you can get from having sex);
- Mental Health medications and services;
- Chemical Dependency services.

Since these types of health information are private, the partners who have your health information cannot give this health information to other people unless you agree or Washington State law says they can give the information to other people. This is true if your health information is on a computer system or on paper.

By signing this consent, I am agreeing that the people I have identified on this form have permission to view my private confidential medical information and may consult with one another to help me manage my health care. This health information may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries you have or may have had before; test results, such as x-rays, or blood tests; and the medicines you are taking now or have taken before.

If you do not sign this form, you will still be able to get services from Fostering Well-Being. **All youth over the age of 13 referred to our unit will be asked if they want to sign this form, whether or not the type of health information in this form applies to you.**

I AGREE to allow the FWB CCU to receive from and share my health information with the partners listed on this form as it applies to:

- All my client records, including Reproductive Health (i.e. birth control, pregnancy, abortion), HIV/ AIDS and sexually-transmitted disease (STD) test results, diagnosis or treatment records (RCW 70.24.105), Mental Health records (RCW 71.05.620), and Chemical Dependency (CD) records (42 DFR Part 2).

OR only the following records (check all that apply):

- HIV/AIDS and STD test results, diagnosis, or treatment
- Reproductive Health (family planning services such as birth control and abortion)
- Mental Health records (RCW 71.05.620)
- Chemical Dependency (CD) records (42 CFR Part 2)
- Other (list): \_\_\_\_\_

I also AGREE that the partners listed on this form may share my health information with each other, and cannot share it with anyone who is not listed on this form. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to my Social Worker or to the FWB CCU. This will not affect any information already shared. Initials: \_\_\_\_\_

Unless previously revoked by me, the specific information above is valid until  I am no longer in foster care, or until

\_\_\_\_\_  
EXPIRATION DATE

PRINT NAME OF CLIENT	CLIENT'S DATE OF BIRTH
CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP OF LEGAL REPRESENTATIVE TO CLIENT

LIST THE NAME OF PARTICIPATING PARTNERS	DATE	CLIENT INITIALS
, Children's Administration Social Worker		
, Foster Parent		
, Primary Care Provider		
, Managed Care Organization		
, Health Home Care Coordinator		
, Tribal Social Worker / Director		