DSHS
WASHINGTON STATE
Department of Social and Health Services

Confidential Health Information Consent Agreement or Withdrawal

Print Name of Client	Client's Date of Birth

You have been referred to the Fostering Well-Being (FWB) program so that our program can help you and others involved in your care understand your health needs. While in out-of-home placement, it is important that your health care providers and others involved in your care be able to communicate with each other to coordinate your health care. At times, your health records may be on a computer system or in writing and may include information about:

- Family planning services like birth control and abortion;
- Sexually Transmitted Infections (STI), are infections or conditions that you can get from having sexual contact, previously known as Sexually Transmitted Diseases (STD), and/or HIV/AIDS; and/or
- Mental / Behavioral Health medications and services; and/or
- Substance Use Disorder services

Since these types of confidential information are private, the partners who have your confidential information cannot share it with other people unless you agree, or Washington State law says they can share the confidential information with other people.

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

By signing this consent, I agree that the people I have identified on this form have permission to view my private confidential information. They may consult with one another to help me manage my health care. My confidential information may include records about illnesses or injuries that I have now or had in the past. Records may include test results (such as X-rays and blood tests), medicines I take now or took in the past, and records from visits to hospitals, provider offices or other clinics and/or facilities.

I understand I can withdraw my consent at any time by signing this form and giving it to my Case Worker or to the FWB program. This will not affect any information already shared.

Section 1:

I **agree** to allow the FWB program to receive and share my confidential information marked below with my Providers and Clinicians including my Department of Children, Youth, and Families (DCYF) Case Worker and/or Tribal Social Worker, my current Caregiver, and Biological Parent(s):

☐ All my client records, including, but not limited to, Medical, Reproductive Health (i.e. birth control, pregnancy, and abortion), HIV / AIDS and STD / STI test results, diagnosis or treatment records (RCW 70.02.220), Mental Health records (RCW 70.02.230), and Substance Use Disorder records (42 CFR Part 2).

OR (if Section 1 is not completed, please complete both parts of Section 2)

DSHS WASHINGTON STATE Department of Social and Health Services

Confidential Health Information Consent Agreement or Withdrawal

Section 2: (Sections 2A and 2B must be completed)

2A. I **agree** to allow the FWB program to receive and share information about my health marked below with only those Provider / Partners marked below:

- ☐ HIV / AIDS and STD / STI test results, diagnosis, or treatment (RCW 70.02.220)
- ☐ Reproductive Health (family planning services such as birth control and abortion)
- ☐ Mental Health records (RCW 70.02.230)
- ☐ Substance Use Disorder records (42 CFR Part 2)

2B. Providers / Partners that the FWB program can share your records with (check all that apply):

- ☐ Medical Providers
- ☐ Current DCYF Case Worker and/or Tribal Social Worker
- ☐ Reproductive Health Providers
- ☐ Current Caregiver / Foster Parent / Kinship Caregiver
- ☐ Providers Clinicians
- ☐ Biological Parent(s) (list first and last names):
- ☐ Other (list):

I also **agree** that the partners listed on this form may share my confidential 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 **checking the box below (using a new DSHS 10-489), signing it,** and giving it to my Case Worker or to the FWB program. This will not affect any information already shared. Initials: _____

Unless previously withdrawn by me, the specific information above is valid until I am no longer in foster care, or until _____.
Expiration Date

☐ I withdraw my consent. Please complete the following signature section.

Client's or Client's Legal Representative's Signature	Date

Print Name of Legal Representative	Relationship of Legal Representative to Client

Notice to Recipients: This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you 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.