CENTER FOR HUMAN DEVELOPMENT & FAMILY SERVICES INC.

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CHDFS HCBS/CFTSS INFORMATION SHARING CONSENT

This form specifies conditions for disclosure of the release of confidential information protected under Federal Confidentiality Laws (42 CFR, Part II). These regulations prohibit any further disclosure of such information by the recipient without specific written consent of the client/Caregiver to whom it pertains or as permitted by regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

I, _____ hereby authorize CHDFS, Inc. (Center for Human Development & Family Services) to receive and/or share medical or other confidential information while participating in the CHDFS HCBS and/or CFTSS program. The information can be received and/or share with the following providers:

CHDFS Inc.
Primary Care Provider: _____
Medical Specialist: _____
Medical Specialist: _____
Psychiatrist: _____
Mental Health Provider: _____
Pharmacy: _____
School: _____

The specific information disclosed can consists of:

☐ Behavioral Health Records	☐ Mental Health Records
☐ Medical Health Records	☐ Prescribed Medications
☐ Family Planning and Emergency Contraception	☐ Abortion
☐ Sexually Transmitted Infection Testing and Treatment	☐ HIV Testing and Treatment
☐ HIV Prevention	☐ Prenatal Care
☐ Labor and Delivery Services	☐ Drug and Alcohol Treatment
☐ Sexual Assault Services	☐ School Attendance, Grades, etc.

I have been advised of the nature of the information requested or shared. I consent to the disclosure of the information AT THIS TIME. I understand that I have the right to revoke this consent at any time except to the extent that action has been taken in reliance on it.

_____ _____
Client Name Date of Birth

_____ _____
Client or Caregiver/Consenter Signature Date

_____ _____
Witness Date