

CHILDREN'S INTERAGENCY AUTHORIZATION TO EXCHANGE  
CONFIDENTIAL HEALTH INFORMATION (PHI)

Child's Name: \_\_\_\_\_

Case#: \_\_\_\_\_

Social Security No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

I authorize the multidisciplinary team to exchange the confidential health information of the above named child among the following team members in order to develop and implement a service plan.

- |  |   |
|--|---|
| <input type="checkbox"/> Transitional Assistance Department          | <input type="checkbox"/> Public Health Department Law Enforcement     |
| <input type="checkbox"/> Jobs & Employment Services Department       | <input type="checkbox"/> Inland Regional Center                       |
| <input type="checkbox"/> Department of Children's Services Probation | <input type="checkbox"/> School District/SB Superintendent of Schools |
| <input type="checkbox"/> Department of Behavioral Health             | <input type="checkbox"/> Other _____                                  |
| <input type="checkbox"/> Office of Alcohol & Drugs                   | <input type="checkbox"/> Other _____                                  |

This authorization is limited to the following specific types of information:

\_\_\_\_\_  
\_\_\_\_\_

- I understand that I can cancel this authorization at any time except for action that has already been taken. I also understand that the cancellation of this authorization must be in writing to the mental health staff of the team.
- If not cancelled earlier, this authorization shall terminate on (date): \_\_\_\_\_
- I understand that I have a right to refuse to sign, or to limit the scope of, this authorization. I have read this authorization carefully and have had my questions answered.
- I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, California law generally prohibits further disclosure of it unless another authorization for such disclosure is obtained from me or is specifically required or permitted by law. **For substance abuse PHI, see the note below.**

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Note: Parents must have legal custody. Legal guardians and conservators must show proof of status.

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**CONFIDENTIAL CLIENT INFORMATION**

The treating physician, psychologist, LCSW or LMFT will sign if approval is needed under the Lanterman-Petris-Short Act (California W&1 Code Section 5328).

NOTE: Information disclosed pursuant to this release is protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to investigate criminally or prosecute any alcohol or drug abuse patient.