



Authorization for Release of Protected Health Information

This authorization is voluntary and therefore you have the right to refuse to sign this authorization. By signing this authorization you are agreeing to participate in a collaborative meeting, potentially with some or all of the agencies listed below. You have the right to inspect and receive a copy of the CPC Referral Form and list of CPC Recommendations. You will receive a copy of this signed authorization.

If you choose not to sign this authorization then a CPC session for your family cannot be scheduled at this time. However, a CPC representative will contact you to discuss further options.

Child/Youth Name: _____

Date of Birth: _____

I authorize Community Partners for Children to obtain, provide, and exchange written, electronic and verbal information regarding protected health information to and with (parent/caregiver MUST initial next to each agency/organization for this form to be valid):

CPC Member Agencies

- ___ Any Baby Can
- ___ ARC of the Capital Area
- ___ Austin Child Guidance Center (ACGC)
- ___ Austin Independent School District
- ___ Austin Travis County Integral Care (ATCIC)
- ___ Cal Farley’s Family Resource Center
- ___ Child & Adolescent Psychiatry, UT Austin
- ___ Del Valle Independent School District
- ___ Lifeworks
- ___ Manor Independent School District
- ___ Maximus (Medicaid Managed Care)
- ___ NAMI Texas
- ___ Pflugerville Independent School District
- ___ SAFE Austin (formally SafePlace)
- ___ Texas Child Study Center
- ___ Texas Dept of Family & Protective Svs
- ___ The Children’s Partnership
- ___ Travis County Health and Human Svs & Veteran Services
- ___ Travis County Juvenile Probation Dept
- ___ TRIAD Program

Affiliated Agencies That Partner with CPC

- ___ African American Youth Harvest Foundation
- ___ ATCIC – Managed Service Organization Provider Network
- ___ Austin Oaks Hospital
- ___ Austin State Hospital
- ___ Center for Child Protection
- ___ Centers for Children and Families
- ___ Community Volunteer (Parent/Youth, not agency affiliated)
- ___ Capital Area Workforce Solutions
- ___ Texas Workforce Commission
- ___ Department of State Health Services
- ___ Seton Shoal Creek Hospital
- ___ Texas Health & Human Svs Commission
- ___ Texas NeuroRehab Center
- ___ Texas Juvenile Justice Department
- ___ Other _____
- ___ Other _____
- ___ Other _____
- ___ Other _____

To better understand the needs of your child and family it will be necessary to review the following types of information during your CPC Family Session. Please initial next to the information to be disclosed:

- | | |
|---|---|
| <input type="checkbox"/> Determination of Intellectual Disability | <input type="checkbox"/> Placement/Hospitalization Discharge Plan |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Medication Information |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Narrative Assessments |
| <input type="checkbox"/> Staff Progress Notes | <input type="checkbox"/> Treatment Plan Reviews |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Doctor Progress Notes |
| <input type="checkbox"/> Psychological Assessment | <input type="checkbox"/> Other _____ |

I understand that this authorization extends to all information contained in my records about mental illness, developmental disabilities, chemical or alcohol dependency, communicable diseases such as HIV and AIDS, genetic information, and any other types of protected health information. **(initial)**

This authorization can be cancelled at any time, in writing, to Community Partners for Children (mail to: Travis County HHS&VS, Attn: Susie Kirk, PO Box 1748, Austin, Texas 78767 or fax: 512-854-5871). However, the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. All written materials are provided to CPC members on the day of the family’s CPC session and collected at the conclusion of the session. Community Partners for Children cannot control how the protected health information will be used by the agency/person who receives it under this authorization.

Unless cancelled or otherwise specified, this authorization will expire one year from date of signature. **Other specified expiration date:** _____

Legally Authorized Representative Signature (LAR/Parent/Legal Guardian):		Date:
Legally Authorized Representative Printed Name:		Relationship to Client: