CRCG Virtual Meeting Telehealth 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 agree to participate in a collaborative meeting online or by phone.

If you choose not to complete this authorization, then a CRCG session for your family cannot be scheduled. However, a CRCG representative will contact you to discuss alternative service options.

Child/Youth Name: _____

Date of Birth: _____

I authorize the Travis County CRCG to obtain, provide, and exchange written, electronic, and verbal information regarding protected health information with the agencies/organizations below.

<u>CRCG Partner Agencies</u> - representatives from these entities are automatically invited to all CRCG sessions and therefore parent/caregiver MUST initial next to each for a CRCG session to be scheduled.

____Any Baby Can
____The Arc of the Capital Area
____Austin ISD
____Centers for Children and Families (Post Adopt)
____Child & Adolescent Psychiatry, UT Austin, Dell Medical School
____Community Volunteer (not agency affiliated)
____Del Valle ISD
____Integral Care
____Maximus (Medicaid Managed Care)
____Partners Resource Network
____Pflugerville ISD
____SAFE Austin
____Texas Child Study Center
____Texas Dept of Family & Protective Svs (CPS)
____Texas Dept of State Health Services
____Texas Health & Human Services
____The Children's Partnership
____Travis County Health and Human Svs
____Travis County Juvenile Probation Dept
____Unbound Now
____Youth Advocate Programs, Inc.

<u>Please list and initial next to any agencies currently or previously involved with child/youth</u>

____Child/Youth Current School District (if not listed above): _____
____Current Child/Youth Therapy Provider (if not listed above): _____
____Current Child/Youth Medication Prescriber (if not listed above): _____
____Current Program/Service Agency:_____
____Current Program/Service Agency:_____
____Current Program/Service Agency:_____
____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 CRCG Family Session. Please initial next to the information to be disclosed:

____CRCG Referral Form (mandatory)
____Determination of Intellectual Disability
____Psychiatric Evaluation
____Treatment Plan
____Diagnosis
____Psychological Assessment
____Juvenile Justice Records/Documentation
____Placement/Hospitalization Discharge Plan
____Medication Information
____Narrative Assessments
____School Records
____Special Education Documentation
____Other_____
____Other_____

_____**(initial)** I understand that this authorization extends to all information contained in my child's records, which may include records regarding mental illness, developmental disabilities, chemical or alcohol dependency, communicable diseases and viruses, genetic information, and any other types of protected health information.

_____**(initial)** I have received the CRCG Family Guide and CRCG Virtual/Telehealth Acknowledgment Form

As a parent/caregiver of a child scheduled for a CRCG meeting, I will receive a copy of this authorization, the CRCG Referral Form, the CRCG Child/Youth Interest Form, and the CRCG Recommendations developed during my CRCG session.

By signing this authorization, I am confirming I understand the information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations. This authorization can be cancelled at any time in writing by email (susie.kirk@traviscountytx.gov) or postal service (Travis County CRCG, Travis County HHS, Attn: Susie Kirk, PO Box 1748, Austin, Texas 78767). However, the cancellation will not affect any disclosures already made prior to receipt of cancellation notice.

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

Legally Authorized Representative Signature (LAR - Parent/Legal Guardian):	**Date:**
Legally Authorized Representative Printed Name:	**Relationship to Child/Youth:**

Authorization explained to LAR and/or LAR signature witnessed by:

Signature: _____Date: _____

Authorization Approved and Accepted by:

CRCG Representative: _____Date: _____