DCBS-1
12/13

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support

INFORMED CONSENT AND RELEASE OF INFORMATION AND RECORDS

Name _____ **SSN** _____

I understand to help my family and I get the services we need the Department for Community Based Services (DCBS) and other agency staff persons may need to share information and records in order to provide or verify eligibility for these services. By signing this form, I give DCBS staff or staff of another agency, authorized to act on behalf of DCBS, permission to get any information needed to see if I am eligible for any assistance program. I also give permission for DCBS and the following agencies or persons listed below to share information and records with one another about services, benefits or treatment provided to me and my family:

Name of Agency or Individual	Name of Agency or Individual	Name of Agency or Individual

My consent includes the following information and records (please put your initials beside each checked item that you consent to):

_____ ☐ Medical and Physical Health Records (not HIV or AIDS)
_____ ☐ Behavorial Health and Psychiatric Records (not Drugs or Alcohol Abuse Patient Records or Psychotherapy Notes)
_____ ☐ Psychosocial History
_____ ☐ Psychological Test Results
_____ ☐ Child Care Records
_____ ☐ Student School Records
_____ ☐ Long-Term Facility and Alternate Care Records
_____ ☐ Statement of Legal Status and Custody
_____ ☐ Home Care and Home Health Records
_____ ☐ Spouse Abuse and Rape Crisis Center Records
_____ ☐ Senior Program Provider Records
_____ ☐ Homeless Shelter Records
_____ ☐ Court Records
_____ ☐ Housing Records
_____ ☐ Residential Records
_____ ☐ Child Support/Spousal Support Records
_____ ☐ SNAP Records
_____ ☐ K-TAP Records
_____ ☐ Medicaid Records
_____ ☐ Child Protective Services Records
_____ ☐ Adult Protective Services Records
_____ ☐ Financial Records
_____ ☐ Employment Records
_____ ☐ Other _____

This consent applies to the following members of my family for whom I have the legal authority to consent:

Member Name	SSN	Relationship	Member Name	SSN	Relationship

I understand that:

- This authorization will be in effect for a period of_____(not to exceed 12 months) from the signature date.
- I may revoke this consent at any time in writing unless action has already been taken based on my consent.
- DCBS will not condition treatment, payment, enrollment or eligibility for benefits on receipt of this form. Signing this form is voluntary, but failing to sign it, or revoking it before the necessary information is obtained, could prevent an accurate or timely response and could result in denial or loss of benefits.
- Information may be disclosed with other DCBS Divisions to assist in obtaining the requested services.
- Information disclosed to DCBS may no longer be protected by the health information privacy provisions of 45 CFR Parts 160 and 164 pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- Information may be disclosed by DCBS without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2 or to comply with the laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.
- I have received a copy of this form. I may also request a copy of the information retained with it.

Signature _____ Date: _____

☐ Client ☐ Parent ☐ Legal Guardian ☐ Other (specify) _____

Signature _____ Date: _____

☐ Client ☐ Parent ☐ Legal Guardian ☐ Other (specify) _____

Witness Signature_____ Date: _____

DCBS Worker (specify program area)_____ Other Agency Staff (specify)_____