

Use of the “Exchange of Information” Form

The form on the next page is intended to obtain parent/guardian consent for providers to communicate. The page after it contains a script that is to be read to the individual. It should be copied on the back of the “exchange of information” form so that the two pages stay together.

Section one: Mark the reason for the exchange of information; it is ok to mark all three boxes. While it is required to include the 3 reasons we may want to communicate, it is not that important which ones you check.

Section two: Ask family to mark all relevant entities. When possible, inquire about a specific person with whom they have worked. In most cases, you can find phone numbers for these entities in your hard-copy Resource Directory or on the LCCN website. Please get the name of the school and obtain release to talk to LCSSU where the schools’ social workers and school psychologists are typically employed. If they provide an “other” get both the name of a contact person and contact information.

Section three: Some families may wish to allow providers to communicate verbally but not to share documents. If that is the case, just check “verbal communication” (and referral paperwork and screening data if appropriate) and move on to the next section. Or, alternatively, you can use a second form to indicate fewer entities that would exchange written documents. One way to approach both section two and three is to ask families if there are any of these they would NOT wish to be included rather than the other way around.

Section four: If the family wishes to allow communication for a period briefer than a year, you should include that on line 3.

Section five: Obtain parent/guardian consent, date the page, sign your name as witness, and note the agency you work for. If the child is older than 12 years of age, he/she can also sign to indicate agreement.

Once complete, contact by telephone the entities of interest and fax the form.

For children 0-5: It is recommended to request consent for all of the following:

- LCSSU (Livingston County Special Services Unit employs school psychologist, social workers, and early childhood program coordinators who will assist with children 2.5-5 years of age)
- LCCN Database (the database, which is housed at LCSSU, will include information on many children receiving services in the county. The de-identified data will assist leaders in evaluating the effectiveness of treatments and determining allocation of resources).
- Child’s Doctor (in the medical home model, physicians are kept in the loop regarding all aspects of their patients’ development)

- Resource Link (for children who do not have a medical home, Resource Link will assist in making a connection with a provider)
- Health Department (the HD can provide numerous kinds of support to the family through Healthy Families, WIC, Family Case Management and other programs.)
- Child & Family Connections (CFC out of Danville is contracted by Department of Human Services to provide early intervention services to children with greater than 30% delays)
- OSF Early Intervention Program (Locally, CFC often utilizes this program to meet children's developmental delays; it also serves children with 0-29% delays)
- Head Start and/or Day care provider as appropriate
- IHR (if the child's needs are likely to require mental health treatment, you may include Institute for Human Resources which is our community mental health center)

For children 6-18: It is recommended to request consent for all of the following:

- LCSSU (Livingston County Special Services Unit employs school psychologist, social workers in all public schools except District429)
- LCCN Database (the database, which is housed at LCSSU, will include information on many children receiving services in the county. The de-identified data will assist leaders in evaluating the effectiveness of treatments and determining allocation of resources).
- Child's Doctor (in the medical home model, physicians are kept in the loop regarding all aspects of their patients' development)
- Resource Link (for children who do not have a medical home, Resource Link will assist in making a connection with a provider)
- IHR (if the child's needs are likely to require mental health treatment, you may include Institute for Human Resources which is our community mental health center)
- Boys & Girls Club and/or Day care provider as appropriate
- Any other agencies involved in the child's care as appropriate



LIVINGSTON COUNTY CHILDREN'S NETWORK

Exchange of Mental Health, Medical, Legal and/or Educational Information

Name: _____ Birth Date: _____

I am allowing these providers to communicate and exchange information for the purpose of:

- Coordinating Services, Assisting in Treatment, Assessing treatment effectiveness

If I check the box, I consent to information exchange with that provider. I have provided the name and number of a contact person where possible:

- School District, Livingston County Special Services Unit, LCCN Database, Child & Family Connections, Medical Provider, OSF Early Intervention Program, Resource Link, Head Start, Institute for Human Resources, LC Health Department, LC Mental Health Board, Probation/Court Services, Commission on Children & Youth, Dept of Children & Family Services, Boys & Girls Club, A Domestic Violence/Sexual Assault Service, Police Dept, Other

Nature of Information:

- Diagnosis, Intake Summary, Screening Data, Verbal Communication, Attendance, Recommendations, Medical History, Referral Paperwork, Social History, Hg/Lead Labs, Developmental History, Classroom Observations, Medications, School Records, Academic Reports, Psychiatric Consultations, AIDS/HIV, Genetic Testing, Discipline Record, Psychological Evaluations, Prognosis, Treatment Plan, Discharge Summary, Emergency Dept Records, Legal Records, Court Service Reports, Substance Abuse, Sexual abuse/assault Records, Other, Progress Notes

MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION THAT FOLLOWS. I understand:

- 1. That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.
2. That this consent may be modified or revoked by me at anytime upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
3. That this consent automatically expires one year from date of signature or on _____ whichever is earlier.
4. That I have the right to inspect or copy information to be released.
5. That failure to consent to such a release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services.
6. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other entity without my specific written consent.

EFFECT OF GRANTING THIS AUTHORIZATION: The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and federal health information privacy laws may no longer protect it. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to your authorization.

I am willing that a reproduction of this consent be accepted with the same authority of the original.

SIGNATURE OF CLIENT: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____ WITNESS: _____ AGENCY: _____

Dear Parent or Guardian,

I am a member of **Livingston County Children’s Network** which is made up of all the groups listed on the back of this page. We are working together to support all parents in Livingston County as they raise their children to be happy, healthy, and successful citizens. We have come to realize that it is becoming harder and harder for families to do this because of all of the stress we and our children are facing in the world today. We are eager to get to know your child and want to be able to offer whatever kinds of support might be helpful to him or her over the next year. In order for us to talk about the needs of your child and all the possible resources which might be available, we need to ask your consent to communicate with one another. You can give us permission by checking the boxes next to the different team members.

You also have the opportunity to indicate the kinds of information you would like for us to share. If you check the “verbal communication” box, that means we can discuss your child’s needs and progress and coordinate opportunities for him or her. If you wish, you can also instruct us to share various documents by checking the boxes provided. This form allows us to exchange information for a year, but you can change your mind about any part of it whenever you want.

Thanks for giving us the opportunity to get to know your child and allowing us to partner with you in fostering healthy development! We hope you will share with your family and friends our vision...

“Families across Livingston County will utilize and value a comprehensive continuum of services to promote children’s social and emotional development which will, in turn, effectively reduce at-risk behaviors and strengthen relationships.”

Parent/Guardian Name(s): _____

Address: _____

Phone Number(s): _____

E-mail: _____

Medicaid Number/ Insurance Provider & Number _____