

CASE MANAGEMENT REFERRAL AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FORM

(not used for DHS/OJA custody kids)

I hereby authorize (Please Print or Type)

Hospital _____
Address _____ City, State, Zip _____

to disclose Personal Health Information for _____, including diagnosis, psychological and physiological assessments and treatment and discharge planning to the following:

Case Management Agency _____
Address _____
City, State, Zip _____
Phone () _____ Contact Person _____

Case managers help you and your families gain access to community services including mental health, medical care, food, clothing, housing, transportation, educational and vocational services that can make the transition home much easier. The entire community is viewed as a potential resource. The focus for the helping process is on your strengths, interests, abilities, knowledge and capabilities, not weaknesses or deficits. The relationship between you, your family and the case manager is characterized by collaboration and partnership. The child and family are viewed as directors of the helping process. Your hospital works with the Case Management Agency and other services to assure you and your child have all the essential services required at the time of discharge. Your case manager continues this process by assisting your family in your community after discharge.

Patient Name _____ SS# _____
Address _____ MC# _____
City, State, Zip _____ Phone () _____
Parent/Guardian Name _____ Secondary# () _____

By signing below, I acknowledge and understand that:

This authorization is voluntary. I may revoke this authorization at any time by writing to _____ at the address above. If I do not revoke this authorization, it will be valid until (date) _____. Personal Health Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.

Please check this box and sign below, if you wish to refuse case management services at this time.

Signature of Consumer (if 14 or over) Date: _____

Parent/Guardian Date: _____

Hospital's Representative Date: _____

One copy to Caregiver, file, and faxed to the chosen CM agency.

The CM Agency has assigned the following Case Manager _____
Phone# _____ to this case. The Case Mgr. will be contacting the hospital and the family to assist in coordination of needed Case Management services prior to discharge.

CM Agency faxes back to the Hospital to file.

Disclosure of Information for CM services – for Hospitals