



Electronic Database Collection Systems
AUTHORIZATION for the COLLECTION OF
INFORMATION
 First Steps Early Intervention Services System
 Children's Special Health Care Services
 Maternal Child Health
 Hoosier Healthwise



PLEASE REVIEW THE FOLLOWING INFORMATION AND HAVE YOUR INTAKE/SERVICE COORDINATOR DISCUSS ANY QUESTIONS THAT YOU MAY HAVE BEFORE SIGNING BELOW.

Child's Name:

Date of Birth:

(Last)

(First)

(MI)

AUTHORIZATION for the RELEASE AND EXCHANGE of INFORMATION
COLLECTED during the ENROLLMENT/SERVICE DELIVERY PROCESS

The programs you are enrolling in are: the First Steps Early Intervention Service System, a program that ensures the provision of early intervention services to eligible children under 36 months of age and their family; Children's Special Health Care Services, a program that provides the primary, specialty, diagnostic and dental related care for medically and financially eligible children 0-21 years of age Hoosier Healthwise the Maternal Child Health Clinics.

Services available through these programs partnerships include screening, evaluation and assessment, service coordination, due process and procedural safeguards and a variety of early interventions, health and medical services that are made available based upon the needs of the child and family.

This authorization covers certain medical ("Protected Health Information"), social and financial information about the eligible child and family, unless an exception is noted below, including: child/family demographic information; health visit information; infant/child visit data; disability/risk factors; problems or factors that prevent the eligible child and family from receiving appropriate services or medical care; appointments made and services received; Individualized Family Service Plan (IFSP) activities, care plans and family financial eligibility information.

We are asking for your permission as parent/legal guardian/emancipated minor/person 18 years of age or older, to collect demographic and service information about you and/or your child and store it electronically in the Indiana State Department of Health (ISDH) and/or Family and Social Services Administration (FSSA) database system(s). Based upon the information collected during the eligibility determination and enrollment process, a multidisciplinary team will work with you to determine your child's needs for services. With your informed, written authorization, only those health care professionals and service providers with a direct need to know and with authorized security clearance will have access to the electronic file or authorizations for eligibility determination services that are required and authorized by you as your child's parent/legal guardian. Statistical and program information, without any child or family identifying information, will be sent to State and Federal agencies that fund these services to meet various reporting requirements.

Individually designated and signed releases are maintained in your child's record at the local System Point of Entry/ISDH/MCH clinics that indicate individuals with whom you have given your informed, written authorization for reciprocal communications including the sharing and receipt of reports. The person(s) receiving this information has a legal and ethical duty to keep the information in a confidential and private manner, and will not release it to anyone else without your written permission unless allowed by law.

By signing this authorization form, you agree to allow information to be collected through the System Point of Entry or state intake personnel for the electronic database collection systems. All aspects of the data collection, maintenance and utilization are protected under the Family Education Rights and Privacy Act (FERPA). All personal information collected will be treated as confidential pursuant to IC 4-1-6 et seq., IC 5-14-3-4 and 410 IAC 3.2-10, 42 CFR §51a. As the parent/legal guardian, access to information stored in the database is also available to you upon request for inspection or copying.

As legal guardian, you authorize the ISDH and/or FSSA database system(s) to distribute information collected during the eligibility determination/enrollment process and service delivery period to the following:

1. Indiana Family and Social Services Administration, the Division of Disability, Aging and Rehabilitation Services, First Steps, and Hoosier Healthwise
2. Indiana Department of Education
3. Indiana State Department of Health
4. U.S. Departments of Education, and Health and Human Services, for the purposes of financial/program audit and monitoring purposes as required by various federal and state regulations.

-OVER-

ENROLLMENT/SERVICE DELIVERY PROCESS

By signing this authorization, I acknowledge that I have read and understand the information for collection and sharing of data contained on the forms. The authorization will remain in effect no longer than 12 months from the date of my signature.

Signature of parent/legal guardian/ participant (if 18+ years of age or emancipated minor)

Date

Signature of Witness: _____

Date:

I understand that I have the right to revoke this authorization, if the revocation is in writing, except to the extent that action has been taken in reliance on this authorization.

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by law