AUTHORIZATION TO RELEASE INFORMATION
Supporting families with substance use disorder
Philadelphia Plans of Safe Care

Introduction

A **Plan of Safe Care (POSC)** is a plan that supports families and infants affected by substance use to remain healthy and safe. The team consists of health care providers, City departments, public health and social service organizations with diverse backgrounds and experience working with families and children. The goal of a POSC is to ensure mother and baby remain healthy and safe, by identifying the needs of the family, referring to City departments and community resources, and strengthening the overall health and well-being of the entire family.

If you are willing to allow the Philadelphia POSC team to support your family for this purpose, please read this form carefully and sign below.

Section 1: General Information

What type of information will we be sharing with community partners?

- Your and your child's name, address, and other demographic information;
- Medical records of your care during pregnancy and your child's care after birth;
- Your substance use treatment history (if you agree in the section below); and
- Your behavioral health diagnosis and treatment history (if you agree in the section below).

Who will see my information?

Your information will be shared by the hospital with City departments that connect families with needed services and supports and community organizations who are members of the POSC multidisciplinary team. The list of departments and organizations can be found below.

What is the purpose of sharing this information?

Sharing this information will enhance service coordination and delivery between the City departments and community organizations listed below, which will allow them to better collaborate and provide services to you.

How will my information be protected?

The POSC team will ensure your information is stored securely. Your name and other information that identifies you will not be shared without your consent. City departments and community organizations are required to keep your information confidential. Information about your mental and behavioral health treatment, substance use treatment, and HIV-related information are also protected by other privacy laws and can only be shared if you specifically agree to share that information.

Who are we sharing this information with for the Plans of Safe Care?

○ **Philadelphia WIC**	○ **Other:**
○ **Infant Toddler Early Intervention**	○ **Other:**
○ **Community Behavioral Health**	○ **Other:**
○ **Office of Addiction Services**	○ **Other:**
○ **Department of Public Health**	○ **Other:**
○ **Maternal Child Centralized Intake**	○ **Other:**
○ **Health Federation of Philadelphia**	○ **Other:**
○ **Department of Human Services (DHS)**	○ **Other:**

Section 2: Special Categories of Information (check each box below to authorize)

☐ **Substance Use**: I agree that information relating to my substance use treatment or my child's treatment can be shared with the POSC team, limited to: substance use and drug treatment history; and current treatment if applicable. I understand that my or my child's alcohol and/or drug treatment records are protected under federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient records (42 U.S.C. 290dd-2; 42 C.F.R. Part 2) and the Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. § 1690.108; 4 Pa.Code § 255.5).

☐ **Mental/Behavioral Health**: I agree that information about my or my child's behavioral health diagnosis and treatment can be shared with the POSC team. I understand that my or my child's mental health treatment records are protected under the Pennsylvania Mental Health Procedures Act (50 P.S. §§ 7101 through 7503; 55 Pa. Code §§ 5100.1 et. seq).

Section 3: Acknowledgement and Signature

I understand that:

- My consent will expire a year after the date it is signed unless I withdraw it sooner.
- I may choose to withdraw my consent by informing any member of the POSC team, verbally or in writing. If I withdraw my consent, no additional information will be shared with the POSC team.
- Signing this form is voluntary. If I choose not to sign this form, it will not affect my ability to obtain treatment, services, or benefits from any organization.
- After it has been released, my health information (except substance abuse, behavioral health, and HIV-related information) is no longer protected by federal privacy regulations such as HIPAA and may be shared again. However, the POSC team will continue to protect your information as described on this form.

By signing this form, I am consenting to the release of my and my child's information

I have been offered a copy of this consent form and have accepted/rejected (circle one) the copy.

_____	_____
Printed Full Name of Individual (Parent or Caregiver)	**Date of Birth**
_____	_____
Printed Full Name of Child	**Date of Birth**
_____	_____
Signature of Parent or Caregiver	**Date signed**

○ Prenatal ○ Initial ○ Follow-up Lead Organization:_____

Plan of Safe Care

Child's Name (first, last):		**DOB**:		**Alternate Caregiver Name:**	
Mother's Name (first, last):		**DOB**:		**Alternate Caregiver Relationship to child**:	
Father's (co-parent) Name:		**DOB:**		**Alternative Phone:**	
Primary Zip code:		**Primary Phone**:		**Email:**	

Family Needs (i.e housing, food, medical care)	Family Strengths and Goals

Support Services

Support Services	Discussed	Active	Referred	Organization	Contact	Comments
*Women, Infants and Children (WIC) food support	☐	☐	☐			
TANF (cash assistance)	☐	☐	☐			
SNAP (food assistance)	☐	☐	☐			
Transportation assistance	☐	☐	☐			
Shelter/housing assistance	☐	☐	☐			
Emergency Food Referral	☐	☐	☐			
Medical Insurance	☐	☐	☐			

Adult Services

Support Services	Discussed	Active	Referred	Organization	Contact	Comments
*Substance Use Assessment and Treatment	☐	☐	☐			
Primary Health Care/OBGYN	☐	☐	☐			
*Maternal Child Centralized Intake (Home Visiting)	☐	☐	☐			
Behavioral Health Treatment	☐	☐	☐			
Domestic Violence/IPV	☐	☐	☐			

○ Prenatal ○ Initial ○ Follow-up Lead Organization:_____

Plan of Safe Care

Smoking Cessation	☐	☐	☐			
Parenting Classes	☐	☐	☐			
Immigration Services	☐	☐	☐			
Other	☐	☐	☐			

Children Services

Support Services	Discussed	Active	Referred	Organization	Contact	Comments
***Early Intervention** (all infants exposed to substances are eligible for EI monitoring)	☐	☐	☐			
***Safe Sleep Education**	☐	☐	☐			
Pediatric Primary Care	☐	☐	☐			
Sub-specialty Medical Care (i.ie neurology, cardiology, etc.)	☐	☐	☐			
Diapers and/or Formula	☐	☐	☐			
Crib and/or Car seat	☐	☐	☐			
Other	☐	☐	☐			

Attendance

Name	Organization/Relationship to Child	Telephone number	Email Address

I acknowledge I have participated in the development of this Plan of Safe Care (POSC), I have a copy of the POSC, I will share the POSC with my child's primary care provider, and I will make reasonable efforts to follow-up with the services and supports listed above.

Client Signature:_____ Date:_____

I, _____provided _____with the POSC upon discharge.

Provider signature:_____ Date:_____

Please fax plan to: PhillyPOSC@phila.gov