State of Rhode Island

Family Court

Release of Confidential Information

Name: _____
Date of Birth: _____

Child's Name: _____
Date of Birth: _____

Juvenile Number: _____

Case Identification Number: _____

Address: _____
_____
_____

Insurance Carrier: _____

I, _____, on behalf of myself and my child, _____, authorize the Department of Children, Youth, and Families (DCYF), Direct Service Providers, my treatment provider(s), and any other person or agency in possession of employment, medical, psychiatric, treatment, educational, mental health, or other documents and records which are deemed necessary for Safe and Secure Baby Calendar (SSBC) purposes, to release such information to the judicial officer or designee(s) from the:

Rhode Island Family Court
Safe and Secure Baby Calendar
Women's Services Department
3rd Floor
One Dorrance Plaza
Providence, Rhode Island 02903
Telephone: (401) 458-5026 Facsimile: (401) 458-5035

The requested information is necessary for the court to make an initial determination as to my eligibility for services through the SSBC and is also required on an ongoing basis to track my progress towards the goals of the case plan. The free flow of information is vital to the success of the SSBC, and I voluntarily consent to the release and re-release of information which is considered necessary for SSBC purposes. I understand that any information gathered or obtained by the SSBC care coordinators, DCYF, the Brown Center for the Study of Children at Risk, Department of Health, medical personnel, and other Direct Service Providers, may be re-released to the SSBC partners for purposes consistent with participation in the SSBC. I further understand that the information, assessments, and reports which have been gathered, prepared, or obtained by the SSBC may be re-released and/or shared with all necessary individuals and agencies involved in my case. (Alcohol, drug, and mental health records include all aspects of diagnosis, treatment, and prognosis. Educational records include all attendance, special service, behavioral, and academic progress reports).

I understand that my records may be protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. part 2, and the health care confidentiality laws of Rhode Island and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires one (1) year after the date signed, unless an earlier date is specified by a formal and effective termination of my involvement with the SSBC. Termination from the SSBC will occur upon the discontinuation of all court supervision as a result of either the successful completion of the SSBC requirements or upon discharge for violating the terms of the SSBC. The SSBC will inform the disclosing agency of the revocation or expiration of consent.

I understand that this is a limited disclosure for the purposes as stipulated above and any disclosure is bound by 42 C.F.R. part 2, which governs the confidentiality of substance abuse patient records. The federal rules prohibit further disclosure of this information unless such a disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. It is a crime to violate this federal confidentiality requirement, which the participant may report to the appropriate authorities. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. However, neither state nor federal law protect information relating to crimes committed on the premises of a program, crimes against program personnel, or the abuse or neglect of a child.

_____ _____
Signature of Participant Date

_____ _____
Signature of Witness Date