ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ *(minor client's name)*.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ *(name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 16 years of age, but only after signed by client.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**