

ANCHOR FAMILY SERVICES INC.
Individual Consent (Foster Parents)

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my care, Anchor Family Services Inc. receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, and diagnoses. I understand that Anchor Family Services, other contracted health care professionals, and staff may use this information to perform the following tasks:

- Evaluate ability to provide foster care
- Complete a home study
- Distribute the home study to TDFPS or other foster and/or adopt agencies
- Evaluate compliance with TDFPS Minimum Standards
- Conduct routine operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of personnel).

I have been provided a **Notice of Information Practices** that fully explains the uses and disclosures that Anchor Family Services Inc. will make with respect to my individually identifiable health information. I understand that I have the right to review the *Notice* before signing this consent. Anchor Family Services Inc. has afforded me sufficient time to review this *Notice* and has answered any questions that I have to my satisfaction. I also understand that Anchor Family Services Inc. cannot use or disclose my individually identifiable health information other than as specified on the *Notice*. I also understand, however, that Anchor Family Services Inc. reserves the right to change its notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision) if it sends a copy of the revised notice to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, Anchor Family Services Inc. may refuse to provide me services unless applicable state or federal law requires Anchor Family Services Inc. to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Anchor Family Services Inc. is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or Anchor Family Services Inc. notifies me that it is no longer going to honor the request.

I request the following restrictions on the use or disclosure of my individually identifiable health information:

I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all treatment plans be mailed to me rather than faxed. I further understand that Anchor Family Services Inc. must honor this request if the *method of communication* is

reasonable. Anchor Family Services Inc. may not ask me why I want the alternate method of communication.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information for facility directories and to family members.

I object to uses and disclosures as follows: _____

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Anchor Family Services Inc. has already taken action in reliance on my earlier effective consent.

Signature of Foster Parent

Date: _____

Signature of Witness

Date: _____