

EIGHTEENTH JUDICIAL CIRCUIT PROBLEM-SOLVING COURTS
EARLY CHILDHOOD COURT - Brevard County, FL
Moore Justice Center • 2825 Judge Fran Jamieson Way • Viera, FL 32940 • (321) 635-5070

Case No(s).: _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
AND CONSENT TO PARTICIPATION AND TREATMENT IN EARLY CHILDHOOD COURT

I, the undersigned participant, hereby voluntarily authorize the disclosure of my confidential treatment records and related health information as described below.

Full Name: _____

Date of Birth: _____ Telephone: _____

Address: _____

I hereby voluntarily consent to participate in the Early Childhood Court (ECC), a program expected to provide me with additional services to support me in the completion of my case plan. I understand that my case will be transferred to the docket for ECC. I will be expected to participate in special planning sessions, case plan conferences, and family team meetings as needed in order to ensure my child(ren) and I benefit from all services provided. Once I enter into Early Childhood Court, I understand that the Judge does not discharge parents from Early Childhood Court except for good cause as determined by the Judge and that for parents who are unable to be successfully reunified, the Court will proceed with another permanency goal.

I understand that as part of the ECC program, outpatient and/or home-based infant mental health services are required. I voluntarily consent, on my own behalf and on behalf of my child(ren), to participate in these services, which may include assessments and therapeutic treatment for me and my child(ren). I further understand that information regarding assessments and treatment will be shared by the ECC Team for the purposes of determining progress in the program.

Persons or Entities Authorized to Receive the Information:

I authorize the following persons or entities to disclose to one another, for the purpose of coordinating, administering, and monitoring my participation in the program, my confidential treatment records and related health information, including my diagnosis, prognosis, program compliance status, substance abuse treatment, and mental health treatment information:

The Early Childhood Court program team members, including the presiding judge, community coordinator, and family time facilitator; State Opioid Response staff as well as case management staff with Family Allies and Family Partnerships of Central Florida; attorneys and staff with Children’s Legal Services/the Department of Children and Families; attorneys and staff with the Office of Regional Conflict Counsel; court-appointed registry parent attorneys; attorneys, staff, and volunteers with the Guardian ad Litem Office; any treatment providers, including but not limited to child parent psychotherapists, Circle of Security Parenting facilitators, anger management providers, parenting assessors, Batterer Intervention Program providers, psychologists, psychiatrists, mental health counselors, and Medication-Assisted Treatment (MAT) and Medication for Opioid Use Disorder (MOUD) providers; and any Florida or federal agency affiliated with the program or providing funding for the program as necessary to show compliance with any funding requirements.

I understand that ECC is a Problem-Solving Court overseen by the Office of the State Courts Administrator (OSCA) with staff who has access to data in the Florida Dependency Court Information System (FDCIS) for purposes of providing administrative oversight, program monitoring and evaluation, and data compliance review. This information includes but is not limited to Substance Use Disorder patient records and treatment information as set forth in 42 C.F.R. part 2 by the United States Department of Health and Human Services. Headquarters staff with the Florida Department of Children and Families (DCF) have access to the data for purposes of program monitoring and evaluation. Therefore, I authorize staff with OSCA and DCF to access my confidential records for these specified purposes.

Purpose of the Disclosure:

I understand that this consent permits the persons and entities identified above to receive information concerning my participation in the program for the purposes described above. I authorize the disclosure of my confidential information only to the extent reasonably necessary and pertinent to those purposes.

I further understand that as an essential component of the program, summary information about my compliance or non-compliance will be discussed in an open and public courtroom, and it is entirely possible that third parties will attend these court hearings and will hear these discussions. I also understand that the above-referenced discussion of my progress will require the disclosure and re-disclosure of confidential treatment information to individuals who may or may not be individually and specifically authorized to receive such information. Accordingly, I hereby specifically consent to any potential re-disclosure to third persons who may attend any of my court hearings.

Expiration of Consent:

I understand that this consent form will be valid and remain in effect as long as I receive services as part of the ECC program, until either successful completion or termination from the program. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on this consent.

Confidentiality:

I understand that my records are protected under federal and state laws, regulations, and rules, including, but not limited to, 42 C.F.R. part 2.

Acknowledgment:

I acknowledge that a copy of this form has been provided and explained to me, and I fully understand and agree to its contents. I further acknowledge that I have been advised of my rights, and have had the benefit of legal counsel or have voluntarily waived the right to an attorney. I am not currently under the influence of drugs or alcohol. I fully understand my rights and I am signing this consent voluntarily.

Signatures:

Participant/Parent Printed Name

Witness Printed Name

Participant/Parent Signature

Witness Signature

Date

Title

Date

NOTICE OF RESTRICTIONS ON USE AND REDISCLOSURE

This record which has been disclosed to you is protected by federal confidentiality rules (42 C.F.R. part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any federal, state, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 C.F.R. § 2.12(c)(5) or as authorized by a court in accordance with 42 C.F.R. §§ 2.64 or 2.65.

In addition, the federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

- (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 C.F.R. part 2;**
- (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations; or**
- (iii) You have received the record from a covered entity or business associate as permitted by 45 C.F.R. part 164, subparts A and E.**

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 C.F.R. § 2.31).