ABBOTT HOUSE
www.abbotthouse.net
100 North Broadway
Irvington, NY 10533
914.591.7300
1775 Grand Concourse
Bronx, NY 10453
718.329.4968
100 Commerce Drive
New Windsor, NY 12553
845.664.7410
Justine Christakos, LMSW, *President and CEO*

Children Waiver's Consent for Information Sharing Related to Services (CFTSS & HCBS Services)

I/We _____ as parent/legal guardian/individual *(if over 18)* of
(please print name)

_____ consent for Abbott House to speak with and/or share
(please print name of individual)

documentation including but not limited to CFTSS Comprehensive Assessments, CFTSS

Treatment plans, and/or HCBS Service Plans to the following providers/people specific to

_____CFTSS and/or HCBS services during the timeframe in
(please print name of individual)

which_____ is enrolled with Abbott House's CFTSS and/or
(please print name of individual)

HCBS services.

I Understand

- The purpose of this disclosure is to authorize, coordinate, and improve treatment/services.
- Consent to release information to the Health Home Care Management Agency and the Medicaid Managed Care Plan is required to receive HCBS/CFTSS services from Abbott House.
- The information shared includes diagnosis, treatment/service plans, progress notes, current treatment/services updates, participation in treatment/services, progress and barriers in treatment/services, safety plans, and discharge/transfer summaries.
- I can change this form at any time. If I make changes, I must initial, and date as indicated within the designated box below.
- I can revoke this authorization at any time by submitting a written letter to Abbott House. This consent form will expire in one year from the date I sign.

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Health Home Care Management Agency (if applicable):	☐ Add ☐ Remove	Date of change:	Initials:
Medicaid Managed Care Plan:	☐ Add ☐ Remove	Date of change:	Initials:
Name of School:	☐ Add ☐ Remove	Date of change:	Initials:
Name of Provider/Organization:	☐ Add ☐ Remove	Date of change:	Initials:
Name of Provider/Organization:	☐ Add ☐ Remove	Date of change:	Initials:
Name of Provider/Organization:	☐ Add ☐ Remove	Date of change	Initials:
Name:	☐ Add ☐ Remove	Date of change:	Initials:
Name:	☐ Add ☐ Remove	Date of change:	Initials:

_____

Print Name of Parent/Legal Guardian/Individual if over 18 Date

_____

Signature of Parent/Legal Guardian/Individual if over 18 Date