PARTNERSHIP FOR STRONG FAMILIES

Requesting Confidential Information from the Florida Child Welfare Client Record

Florida Child Welfare Records are confidential and exempt from the public record. Authorized Parties have the right to request and obtain confidential information from the child welfare record.

We have attached forms to help gather the information we need to process the request. Requestors are not required to use our forms but if using an alternate request format, please include the same information requested by the forms.

To protect the confidentiality of the information, we are required to confirm the requestor's identity and status as an authorized party. Normally we use state issued identification to do this.

We have attached an authorization form for requests for releases to third parties.

For requests from attorneys, in lieu of identification, please provide a copy of the court order appointing the attorney or provide a copy of the client's authorization to release information to the attorney.

To protect the confidential information of third parties in a case file or other information that is exempt from release, Federal and State law requires us to redact certain information from the records before we can release the records. For example, we cannot release information or records concerning certified domestic violence centers, the identity of persons reporting child abuse, neglect or abandonment, or other information the requestor is not authorized to see. The redaction process can take a while, depending on the amount of information that requested and the number of record requests pending.

Sometimes a case file contains third-party documents that we do not have authorization to release. In this instance, we will notify the requestor where we obtained the record so they can make a direct request. If requesting information that requires an order from a court of jurisdiction to release, please attach a copy of the order to the request.

We can fulfill the request for as long as we have a copy of the records. Florida regulations determine how long to keep a copy of a child welfare case file before destroying it. As of June 2013, regulations require the state to store a copy of the case file until the child welfare client reaches 30 years of age. If requesting your own child welfare case and the case closed because you were adopted, we cannot release your child welfare case records to you until after your 18th birthday.

When the records are ready to be released, we attempt to contact the requestor to confirm the address on the request so that we deliver the records to the correct location. Requestors also have the option to arrange to pick up the records from any Partnership for Strong Families office. Requestors will need to show a photo ID at the time of pick-up.

Partnership for Strong Families is a community-based care lead agency contracted with the Department of Children and Families.

Partnership for Strong Families • Records Department
5950 NW 1ST Place Suite 300 • Gainesville FL 32607-6065
request.records@pfsf.org • Ph 352-646-4484 • Fax 352.244.1647

Records Request for Confidential Client Information

Please complete and submit this form to request a copy of child welfare case records.
State and federal law may require the redaction of certain information from the records.
Requestor's can use their agency ID or state ID to confirm their identity.

SUBJECT OF THE RECORD ☐ Check this box if Subject is known to be adopted.

Whose records are you requesting _____

Subject's Date of Birth _____

ADDITIONAL SUBJECT INFO *(Not required. Complete only if known.)*

Subject's Case Name(s): _____

If adopted, pre-adoptive name(s): _____

REQUEST - I, the undersigned, hereby request a copy of:

- ☐ All available records for the subject's case file.
- ☐ The available Dependency Court records from the subject's case file.
- ☐ The available Health records from the subject's case file.
- ☐ The available Education records from the subject's case file.
- ☐ The following specified confidential records:

Please release the records by: ☐ E-mail Link ☐ USB Drive ☐ CD-ROM ☐ Paper (*Select One*)

REQUESTOR INFORMATION

Name of Requestor: _____

Relationship to Subject: ☐ Self, ☐ Subject's Attorney, ☐ Parent, ☐ Custodial Caregiver, ☐ Parent's/Custodial Caregiver's Attorney, ☐ Guardian Ad-Litem, ☐ Child Welfare Agency,

☐ Other: _____

Unauthorized parties must attach the subject's authorization to release confidential information, the court order to release, or the court order appointing the attorney making the request.

Reason for Request: _____

Phone Number of Requestor: _____

E-mail of Requestor: _____

Mailing Address of Requestor _____

City, State, Zip of Requestor _____

_____ _____

Signature of Requestor | Date of Request

PARTNERSHIP FOR STRONG FAMILIES

Authorization for Release of Confidential Information

Including Testimony by Behavioral and Medical Healthcare Providers

PSF is a Community-based Care Lead Agency contracted with the Florida Department of Children and Families

I, the undersigned, hereby authorize the following agent of Partnership for Strong Families, Inc.

ALICIA KULP	352-646-4484	request.records@pfsf.org
Name	Phone	e-mail address

located at (address): Gainesville Service Center 5950 NW 1ST PL STE 300 GAINESVILLE FL 32607

to: (Mark one.) ☐ **exchange** information with: ■ **release** information to: ☐ **obtain** information from:

Name & Address of Provider or of Authorized Party: _____

Examples of Provider or Authorized Party Types: Adoption Agency, Agency for Persons with Disabilities, Behavioral Healthcare Provider, Employer, Daycare or Preschool, Dental Care Provider, Department of Juvenile Justice, Detention Center, Domestic Violence Shelter, Guardian Ad Litem, Hearing and Speech Provider, Medical Care Provider, Meridian Outpatient Services (SA, MH, TCM and MAT), Meridian Crisis Services (CSU, Detox), Meridian Inpatient Services (MIST, Bridge House, Recovery), Probation or Parole Officer, Psychiatric Care (Psychiatrist), Residential or Therapeutic Care, School, Social Security Administration, Substitute Caregiver or Foster Parent, Substance Abuse Treatment, Vision Care, Vocational Rehabilitation, etc.

Type: _____ **about the following client:**

Client's Last Name	First Name	M.I.	Date of Birth	Social Security #

Type of Information

■ Child Welfare	■ Dental	■ DSM Diagnoses
■ Court / Legal	■ Medical	■ Vision
■ Employment	■ Medications / Prescriptions	■ Disability
■ School or Education	■ Immunizations	■ Behavioral Health Assessments/Evaluations
■ Life/Job Skills Training	■ Domestic Violence Treatment	■ Behavioral Health Treatment Plans
■ Hearing and Speech	■ Sex Offender Treatment	■ Behavioral Health Tx Progress Status Reports
■ Parenting Skills	■ Sexually Transmitted Infections	■ Behavioral Health Discharge Summaries
☐ Other (Please specify):	■ HIV / AIDS	■ Psychiatric Medical
		■ Drug Screen Results
		■ Substance Abuse Treatment

Term ■ A single disclosure or ☐ Continuing disclosures until: _____ *Maximum term is 1 year.*

Information Date Range From: _____ To: _____ *Tx/Service/Record Dates*

Information Format ■ Electronic ■ Verbal ■ Written *Mark all that apply*

The purpose or need for disclosure is: *(Mark all that apply.)*

☐ Assessment	☐ Child Welfare Services / Family Support Services
☐ Continuity of Care	☐ Court / Legal Proceedings / Testimony
☐ Third-Party Payment	■ Other: Records Request

I understand that the information released to or by Partnership for Strong Families pursuant to this authorization may not be re-released without a separate written authorization, except as required or permitted by law. I also understand that if the authorized recipient is not a healthcare provider or other entity covered by federal privacy regulations, then the authorized recipient may potentially re-release the information obtained pursuant to this authorization without obtaining additional authorization. I understand that I may revoke all or any part of this authorization at any time, except to the extent that action has already been taken, by writing to: PSF Privacy Officer, Partnership for Strong Families, 5950 NW 1st Place Suite 300, Gainesville FL 32607. I acknowledge that this form has been explained to me and that I have been offered a copy.

Signature (Client/Guardian/Personal Rep.)	Printed Name (Client/Guardian/Personal Rep.)	Date

Signature of Witness	Printed Name of Witness	Date