MIECHV Database Informed Consent

Name of Adult Participant: _____DOB: _____
(Last) (First) (M) (Month/Day/Year)

Name of child participant* (1):_____DOB:_____

Name of child participant (2):_____DOB:_____

Name of child participant (3):_____DOB:_____
*Any child whose information will be entered into the data system should be listed even if the child is not the target child.

It is important that you read the following. If there is anything that you do not understand or if you have any questions be sure to ASK.

Welcome to the Illinois Maternal Infant and Early Childhood Home Visiting Program (MIECHV). MIECHV agencies use a data management system to collect confidential data on individuals receiving home visiting services. These services include Healthy Families Illinois, Parents as Teachers, and Early Head Start.

We are asking for permission to collect Information about you and your family and store it in a centralized computer system maintained by the Illinois Department of Human Services and the Illinois Governor's Office of Early Childhood Development. Only those authorized professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund this program.

By signing this consent form, you agree to allow certain information to be collected by this agency. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize _____ (Agency Name) to collect information during the duration of Home Visiting services.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; DCFS State Central Registry reports, appointments made and services received; goals and care plan; program information; information required by the federal Maternal Infant and Early Childhood Home Visiting Program. Any information you do not want released should be written in Part C.

C. I do NOT want the following information to be shared: _____

D. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and The Illinois Governor's Office of Early Childhood Development liable for the release of any information about me in accordance with the terms of this consent form.

E. A copy or facsimile of this consent will be as valid as the original.

F. This consent form is valid until _____, _____. *Expiration date shall not be longer than one year from date of execution.
(Month, Day) (Year)*

The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.
A general authorization for the release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)

NOTE: Your refusal to sign a MIECHV Database Informed Consent form will not prevent treatment, payment or enrollment in a health plan or eligibility for benefits.

_____ OR _____
Signature of parent/legal guardian/caretaker/Date Signature of adult participant /Date

Signature of Witness (Required): _____ Date: _____