

# ADOPTION GUIDELINES FOR INDIANA HOSPITALS

Prepared through a joint effort between:

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(Revised 3/11/1996, 11/10/2000, 3/30/2006, and 10/13/2014)

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## **INTRODUCTION:**

These proposed guidelines may be wholly adopted by a hospital for use as its adoption policy or they may be used as a checklist against which an existing policy may be compared to verify that the existing hospital policy covers the matters contained in these proposed guidelines. A hospital should follow whatever procedure the hospital has already established for the enactment of guidelines and should have the attorney for the hospital review these guidelines before they are adopted in whole or in part. ***Co-author of these proposed guidelines, Steve Kirsh, is available to assist hospitals tailor these proposed guidelines to the needs of individual hospitals. He can be contacted directly at 2930 E. 96<sup>th</sup> Street, Indianapolis, IN 46240, (317) 575-5555, or steve@kirsh.com.***

The in several places “[**Note:**]” will appear. These are intended a drafting explanations and should be deleted when these guidelines are incorporated into hospital policy. Other explanations are included as footnotes. Those explanations should be incorporated into hospital policy.

## **I. GENERAL REQUIREMENTS**

- A. The hospital shall take an "adoption-neutral" position in regards to adoptions which take place at the hospital. In other words, the hospital personnel shall neither discourage nor encourage the mother to proceed with an adoption plan for the infant. However, if a mother chooses to proceed with an adoption, hospital personnel shall fully support her decision. Also, this provision should not be construed so as to prevent the “adoption coordinator” (defined below) from discussing adoption with patients who might, for themselves or their children, benefit from such a discussion. A good way to quickly gauge a patient’s feelings about her situation is to ask: “How do you feel about being pregnant (or having just had a baby)?” How she answers will immediately let the adoption coordinator know if adoption should be offered as an option.
- B. Whenever a patient presents at the hospital for delivery, whether or not adoption is considered, the hospital has two patients – the mother and infant. The hospital shall always strive to do what is in the best interests of both patients.

- C. Indiana recognizes two types of adoptions:
1. Agency adoption. This is an adoption handled by a child-placing agency licensed in Indiana.
  2. Private/independent adoption. This is an adoption which is not facilitated by a licensed child-placing agency.
- D. For the purpose of these guidelines, whether the adoption will be an agency adoption or a private/independent adoption, the person making the arrangements for the adoption shall be referred to as the "adoption facilitator." Do not confuse this term with adoption facilitators who are unlicensed, unregulated entities who often advertise in the yellow pages and on the Internet. For a fee, those entities find babies for prospective adoptive parent(s).<sup>a</sup> In these guidelines the term "adoption facilitator" refers to a either an attorney licensed to practice law in Indiana or a child placing agency licensed in Indiana.
- E. For the purpose of these guidelines, the hospital representative primarily responsible for coordinating the arrangements for the adoption in the hospital shall be referred to as the "adoption coordinator". The duties imposed upon the adoption coordinator may be discharged by one or more hospital personnel. **[Note:** In some hospitals, the duties of the adoption coordinator will primarily be fulfilled by a social worker or discharge planner. In other hospitals, the OB supervisor will assume this role. In still other hospitals, the duties may be divided among a number of individuals including social services, nursing, and business office personnel. Many hospitals will designate a backup person or persons to assume the duties of the adoption coordinator on weekends and holidays and when the designated adoption coordinator is otherwise unavailable.]
- F. In an adoption, the mother may sign one or more of the following documents:
1. **Consent to adoption.** This document may be used in either an agency adoption or a private/independent adoption. The legal effect of a consent to adoption signed for an adoption agency is exactly the same as the legal effect of a consent to adoption signed in a private/independent adoption. Under Indiana law, a consent to adoption is irrevocable upon signing. In order for a consent to adoption to be withdrawn, the person signing the consent would have to petition the court and then prove that it would be in the best interests of the child for the consent to adoption to be withdrawn. Indiana does not afford a person signing a consent to adoption any period of time after signing the consent to unilaterally withdraw it. If the adoption will be filed in another state, the laws of that state may

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<sup>a</sup> **Under Indiana Code § 35-46-1-22, it is a crime for these unlicensed, unregulated entities to provide "adoption services" to birth parents in Indiana. Only attorneys and adoption agencies licensed in Indiana may provide "adoption services" to birth parents.**

govern the revocability of the consent. Some states accord a birth parent a period of time after signing the consent to revoke it. Indiana does not. **Under Indiana Code § 31-19-9-2(b), a mother CANNOT sign a consent to adoption prior to the birth of a child. A consent signed prior to birth is not valid. An order of custody based upon an invalid consent is also not valid.** If the adoption coordinator is aware that the mother signed a consent to adoption prior to birth of the child and a court order was obtain in reliance on the pre-birth consent, the adoption coordinator shall immediately contact \_\_\_\_\_. [Note: The contact will vary from hospital to hospital but may include hospital administration, risk management, legal department, and etc.]

2. **Consent to termination of parental rights.** This document may only be used in an agency adoption. A consent to termination of parental rights is not revocable if properly executed. **Under Indiana Code § 31-35-1-6(d), a mother CANNOT sign a consent to termination of parental rights prior to the child. A consent signed prior to birth is not valid. An order of custody based upon an invalid consent is also not valid.** If the adoption coordinator is aware that the mother signed a consent to termination prior to birth of the child and a court order was obtain in reliance on the pre-birth consent, the adoption coordinator shall immediately contact \_\_\_\_\_. [Note: The contact will vary from hospital to hospital but may include hospital administration, risk management, legal department, and etc.]
  
3. **Relinquishment of custody.** This document may only be used in an agency adoption. By means of this document, the mother is authorizing the adoption agency to assume custody of the infant at the time of discharge. By itself, a relinquishment of custody may be revoked at any time by the mother. Either contemporaneously with the signing of a relinquishment of custody or at some later date, the adoption agency will ask the mother to sign either a consent to adoption or a consent to termination of parental rights. Once she signs a consent to adoption or a consent to termination of parental rights, her decision becomes irrevocable.

B. In a private/independent adoption, the adoption facilitator must provide to the hospital a court order authorizing the discharge of the infant.

1. The court order must include the following information:
  - a. The name of the infant. "Infant Male-Female (mother's surname)" is sufficient.
  - b. The name of the person to whom the infant is to be discharged. This may be either the adoption facilitator or the prospective adoptive parent(s), or both.

- c. A provision such as:

"IT IS, THEREFORE, CONSIDERED AND ORDERED that Petitioners shall have custody of the Child pending the entry of a final decree of adoption and that \_\_\_\_\_ (name of hospital), be, and it is hereby, permitted and authorized to release and discharge the Child to the custody of Petitioners, \_\_\_\_\_ and \_\_\_\_\_ (legal names of adoptive parent(s)) either directly or by and through their attorney, \_\_\_\_\_ (name of attorney) all subject to the approval of the attending physician".

- d. The order must be certified and signed by the judge.

- 2. A faxed copy of the court order shall be sufficient so long as the adoption facilitator agrees to promptly provide a "hard copy" of the court order.

C. In an agency adoption, unless the adoption agency has the birth mother sign a relinquishment of custody form and provides to the hospital an originally executed copy of the document, the adoption agency must also provide a court order meeting the same requirements for a court order in a private/independent adoption.

D. If an adoption agency provides a relinquishment of custody form to the hospital, that form must include the following:

- 1. The mother's name.
- 2. An express authorization from the mother that the hospital may release the infant to a representative of the adoption agency.
- 3. A copy of the adoption agency's current license as a child-placing agency.
- 4. A provision such as:

"I, \_\_\_\_\_ (name of mother), hereby relinquish custody of my child born on \_\_\_\_\_ into the custody of \_\_\_\_\_ (name of adoption agency).

## II. PRIOR TO ADMISSION

A. The adoption facilitator should contact the adoption coordinator at the hospital to inform the hospital that the mother is considering an adoption plan. The information which the adoption facilitator should provide is as follows:

- 1. The mother's name.

2. Estimated Date of Confinement.
  3. The name of her doctor.
  4. Her age.
  5. Whether or not she is married.
  6. Any special circumstances which may help the hospital be prepared for the adoption.
- B. The adoption coordinator shall request that the adoption facilitator provide a confirming letter to the hospital covering:
1. An overview of the arrangements.
  2. The financial arrangements.
  3. The mother's requests for her stay at the hospital (see Birth Mother Request Form, Form 1). If the adoption facilitator does not use such a form, the adoption coordinator should provide to the adoption facilitator a copy of the Birth Mother Request Form and request that the completed form be returned to the adoption coordinator prior to the mother's admission in labor.
- C. The adoption coordinator shall notify the business office of the financial arrangements and provide a copy of the adoption facilitator's confirming letter, if possible.
- D. Upon receipt of the completed Birth Mother Request Form, the adoption coordinator shall circulate a copy of the request form to labor and delivery to be included on the mother's chart upon her admission in the hospital.
- E. The adoption coordinator shall inform the adoption facilitator of the hospital policies regarding adoptions which take place at the hospital including:
1. A consent to adoption may not be signed in the hospital sooner than 24 hours after birth, unless the mother, after consulting with the adoption coordinator, requests that the consent be signed sooner than 24 hours and the adoption coordinator is satisfied that the mother is fully aware of the consequences of her action. In no event may a consent to adoption be signed sooner than 12 hours after birth. The adoption coordinator shall note her conversation and the mother's decision on the mother's chart.
  2. In the event of a Caesarean section delivery, a consent to adoption may not be signed sooner than 48 hours after birth, unless the mother, after consulting with the adoption coordinator, requests that

the consent be signed sooner than 48 hours and that the adoption coordinator is satisfied that the mother is fully aware of the consequences of her action. In no event may a consent to adoption be signed sooner than 24 hours after birth. The adoption coordinator shall note her conversation and the mother's decision on the mother's chart.

3. In order for the infant to be released to a person other than the mother or to a child-placing agency licensed in the State of Indiana, a court order authorizing release must be presented to the hospital at the time of discharge.
4. The adoption facilitator or the prospective adoptive parent(s) will be expected to make appropriate financial arrangements with the business office prior to the discharge of the infant.
5. The mother has the right to have whatever contact she wishes with the infant in the hospital until the hospital is presented with an order of custody. With the approval of the adoption facilitator or prospective adoptive parent(s), the mother may continue to have contact with, and care for, the infant until the infant is discharged. If the infant will be hospital beyond the stay of healthy newborn, the adoption coordinator needs to clarify with the adoption facilitator or prospective adoptive parent(s) whether or not the mother may come back to the hospital to visit the infant after the mother has been discharged from the hospital. Once the hospital receives the order of custody, it is up to the adoption facilitator or prospective adoptive parent(s) to approve the mother's contact with, and care for, the infant.

### III. ADMISSION INTO LABOR

- A. Immediately upon admission, the adoption coordinator, or the charge nurse, shall have the mother sign an authorization to release medical information for herself and the infant (Forms 5a and 5b), unless the adoption facilitator has already supplied to the hospital the Hospital Request Form (Form 1). **This is an essential requirement in order to comply with HIPAA Requirements.**
  1. The release of information for the mother shall be placed on her chart. **Care should be taken not to include any of the prospective adoptive parent(s)' identifying information in the mother's medical records other than their first names, because she will have access to those records indefinitely.**
  2. The release of information for the infant shall be placed on the infant's chart.
- B. The adoption coordinator shall ask the mother if she is still considering an adoption plan for the infant.

1. If she is not considering adoption, the adoption coordinator shall advise the appropriate hospital personnel and the adoption facilitator of the decision.
  2. If she is still considering adoption, the adoption coordinator shall
    - a. Remind the appropriate hospital personnel of the plan and that they should try to accommodate her wishes as expressed on her Hospital Request Form or otherwise expressed to the hospital to the extent reasonably possible;
    - b. Notify the adoption facilitator that the mother has been admitted in labor; and
    - c. Place a photograph of pine tree on the door to the mother's room to alert hospital staff of the adoption. **[Note:** A photograph of anything can be used so long as it does not reference adoption. For example, some hospitals will place a photo of a butterfly on the door of a patient whose child was stillborn.]
- C. If the mother requests that the adoptive parents be present during labor and delivery, in addition to the having the mother sign authorizations to release medical information for herself and the infant (Forms 5a and 5b), which include the prospective adoptive parents as "Recipients" of protected health information, the adoption coordinator shall have the mother sign the Attendance Request Authorization (Form 6). With these forms being signed by the mother, the prospective adoptive parent(s) may be present during labor and delivery, and the nursing staff need not be concerned about keeping the mother's identifying information from the prospective adoptive parent(s). Furthermore, the prospective adoptive parent(s) may be given one of the infant's bands for identification purposes. Having these forms signed eliminates the need for "rebanding" the infant – a procedure some hospitals follow in order to avoid disclosing identifying information to the prospective adoptive parents. The mother retains the right to have the adoptive parents leave the labor room upon her request.
- D. If the mother would like the prospective adoptive parent(s) to have contact with and care for the newborn in the hospital, the adoption coordinator shall have the mother sign the Infant Care Authorization (Form 3). This form can be signed before or after birth. As with the Attendance Request Form (Form 6), this form eliminates the concern about keeping the mother's information confidential and "rebanding" of the infant.
- E. If the mother arrives at the hospital for delivery and expresses a desire to make an adoption plan for the infant, without having made prior

arrangements for an adoption, the adoption coordinator shall talk with the mother to determine if she understands her options for the infant. After that consultation, if the mother still wishes to have more information about adoption, the adoption coordinator shall give mother a list of adoption facilitators containing at least one adoption attorney and one adoption agency licensed in Indiana. Adoption law is a highly technical area of the law. Statutory procedures must be carefully followed. In order for an attorney to be included on the list, the attorney must be licensed to practice law in Indiana, and a substantial part of the attorney's law practice must be devoted to newborn adoptions, which are not the same as step-parent adoptions. The co-author of these guidelines, Kirsh & Kirsh, P.C., satisfies these two requirements. The adoption coordinator shall **not** include on the list any person or entity that does not maintain a place of business in Indiana and shall not include any person that is not an attorney or a licensed-child placing agency.<sup>b</sup> The adoption coordinator may give preference to those attorneys and agencies who have previously handled adoptions at the hospital in a professional, caring, and efficient manner. It is not good practice to simply supply the mother with a telephone directory or access to the Internet and have the mother contact whomever she wishes, any more than it would be good practice to refer her to a physician in that way.

#### **IV. AFTER BIRTH OF INFANT**

- A. When the adoption coordinator feels it appropriate, the adoption coordinator shall speak with the mother and ask if she is still considering an adoption plan for the infant and communicate that information to the adoption facilitator.
- B. The adoption coordinator shall coordinate the arrangements with the adoption facilitator to come to her hospital to have the mother to sign the appropriate documentation for the adoption. It is not the responsibility of the adoption coordinator to have the mother sign the documentation needed by the adoption facilitator. The adoption facilitator will need to come to the hospital to have its documentation completed.
- C. The adoption coordinator may witness or arrange for another hospital staff member to witness the signing of the appropriate documentation.
- D. The adoption coordinator shall have the mother sign a Discharge Authorization (Form 2).
- E. The adoption coordinator shall coordinate the arrangements for the discharge of the infant.
- F. If the adoption facilitator or prospective adoptive parent(s) requests that a

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<sup>b</sup> Some entities advertise themselves as adoption agencies, when in fact, they are unlicensed facilitators (not to be confused with "adoption facilitator" used in these guidelines), who, for a fee, do nothing more than find babies for prospective adoptive parent(s).

male infant be circumcised, the mother shall sign a consent to circumcision. **If the mother has elected not to know the sex of the infant, the circumcision consent form should be signed prior to the birth of the infant so as not to inadvertently disclose to the mother the infant's sex.** The adoption facilitator or prospective adoptive parent(s) shall also sign a consent to circumcision. The infant is not to be circumcised until both the mother and the adoption facilitator or prospective adoptive parent(s) sign the consent to circumcision; however, if the hospital has been provided a court order giving the prospective adoptive parent(s) custody of the infant, the mother's consent is not necessary. A faxed copy of the adoption facilitator's consent to circumcision shall be sufficient.

- G. Medical information may be released to the adoption facilitator or prospective adoptive parent(s) as provided in the Release of Medical Information Section of these guidelines.
- H. After the birth of an infant who is born out of wedlock, the infant's mother and a man who reasonably appears to be the infant's biological father shall be given an opportunity to execute a paternity affidavit on a form provided by the State Board of Health; **provided, however**, except in extenuating circumstances, a paternity affidavit should **not** be executed until after the man has executed a consent to adoption or a consent to termination of his parental rights with the adoption facilitator. If the mother and the man are desirous of executing a paternity affidavit before a consent to adoption or a consent to termination of parental rights is signed by the man, the adoption coordinator shall consult with the adoption facilitator and shall stress to the mother and to the man that the man must be available to sign a consent to adoption or a consent to termination of his parental rights at the time arranged with the adoption facilitator, if adoption is still their plan for the infant. This is very significant because if a paternity affidavit is executed, the man becomes a "legal father" of the infant. In effect, he acquires a veto over the adoption by simply refusing to consent to the adoption. Accordingly, if a man were to sign a paternity affidavit and not make himself available to sign a consent to adoption or a consent to the termination of his parental rights, the mother would not be able to proceed with an adoption plan. Therefore, only except in unusual circumstances should a paternity affidavit be signed prior to the man signing a consent to adoption or a consent to termination of his parental rights.

A paternity affidavit is not valid if it is executed more than 72 hours after the infant's birth or after the mother of the infant has executed a consent to the adoption and a petition to adopt the infant has been filed. The adoption facilitator shall be provided a copy of the executed paternity affidavit.

- I. Prior to the mother's discharge from the hospital, she will need to complete the forms necessary to have birth certificate created for the infant. She may, but is not required, to use as the infant's name the name

the prospective adoptive parent(s) have chosen for the infant. After the adoption is final, a new birth certificate will be created for the infant, listing the adoptive parent(s) as the parents of the child. The name of the infant on the post adoption birth certificate will be the name given by the adoptive parent(s).

- J. Until the hospital is presented with one of the following, all decisions regarding the infant's medical care in the hospital shall be made by the mother:
1. Order of custody.
  2. Relinquishment of custody.
  3. Authorization for Treatment signed in compliance with Indiana Health Care Consent Statute in which the mother specifically authorizes another person to make decisions about the medical care of the infant. (Form 4)
- K. Visitation between the prospective adoptive parent(s) and the infant within the hospital is to be determined by the mother. The prospective adoptive parents may visit the mother and the infant if that is the wish of the mother. Likewise, they may feed, provide care to, and skin-to-skin contact with, the infant, so long as the mother gives her approval. The mother may rescind this authorization at her discretion. If the mother would like for the prospective adoptive parents to feed and provide care to the infant, the adoption coordinator shall have the mother sign an Infant Care Authorization ( Form 3). The mother's granting the prospective adoptive parent(s) the right to visit with, care for, and have skin-to-skin contact with, the infant does not prevent her from doing the same with the infant. If the mother would like the prospective adoptive parent(s) to spend the night in the hospital with the infant and there is space available, the prospective adoptive parent(s) shall be given a room on the post-partum floor.
- L. In an adoption in which the mother signs a consent to adoption or a consent to termination of parental rights, if the mother will be discharged from the hospital prior to the receipt of an order of custody by the hospital, the adoption coordinator shall have the mother sign an Authorization for Treatment (Form 4).

The reason for the authorization for medical treatment is that unless the mother relinquishes custody of the child to an agency, the signing of a consent to adoption or a consent to termination of parental rights only serves as authorization for the court to issue an order granting the prospective adoptive parent(s) custody of the child. Until the court actually issues the order granting the prospective adoptive parent(s) custody of the child, the mother of the child has legal custody of the child. Because she has legal custody of the child, she is still responsible for making medical decisions for the child. By having the mother sign a medical authorization form, she is authorizing the adoption facilitator or the prospective adoptive

parent(s), or both, to make medical decisions during the time period between which she signs the consent to adoption or consent to termination of parental rights and the time the court receives an order of custody. It is particularly important that the mother sign an authorization for treatment when she is discharged from the hospital and the infant will not be discharged until the following day or later.

If the mother does not sign an authorization for medical treatment, until the hospital is informed that an order of custody has been issued, the mother is responsible for making all medical decisions for the child.

- M. If the mother does not object to the prospective adoptive parent(s) knowing her name, the adoption coordinator shall have the mother sign the Authorization to Bill Insurance (Form 7) and give the form to the billing office of the hospital.

## V. DISCHARGE

- A. The adoption coordinator shall coordinate the arrangements for the discharge including:
1. Verifying that the infant's attending physician has discharged the infant.
  2. That the mother's wishes are fulfilled as much as possible. For example:
    - a. That she has been discharged before the infant.
    - b. That the infant is discharged before her, or
    - c. That she is present at the time of discharge.
    - d. That she be given any mementos from the birth, such as the crib card, the infant's hat, the infant's foot prints, and etc. If she does not wish to have these mementos, the adoption coordinator shall give these items to the adoption facilitator to place in safekeeping for her should she request them at a later date.
- B. The infant may not be discharged to anyone other than in accordance with general hospital policy unless the hospital is provided either a court order or a relinquishment of custody.
1. The adoption coordinator shall confirm that the court order for discharge or the relinquishment of custody form contain the appropriate provisions.
  2. **Under Indiana Code § 31-19-9-2(b), a mother cannot sign a**

**consent to adoption prior to the birth of a child. A consent signed prior to birth is not valid. An order of custody based upon an invalid consent is also not valid.**

If the adoption coordinator is aware that the mother signed a consent to adoption or consent to termination prior to birth of the child and a court order was obtain in reliance on the pre-birth consent, the adoption coordinator shall immediately contact \_\_\_\_\_. [Note: The contact will vary from hospital to hospital but may include hospital administration, risk management, legal department, and etc.]

- C. The adoption coordinator shall verify the identity of the infant being discharged by comparing the identification bands with the hospital chart.
- D. The adoption coordinator shall verify the identification of the person identified in the court order for discharge or the relinquishment of custody form by checking photographic I.D., and shall make a photocopy of the photographic I.D. to be attached to the order of custody or the relinquishment of custody.
- E. The adoption coordinator shall place a copy of the order of custody or a relinquishment of custody on the infant's chart.
- F. The person identified in the court order for discharge or the relinquishment of custody form shall sign the discharge authorization under the section entitled "receipt of custody" and shall sign any other documents which the hospital uses in conjunction with the discharge from the hospital of infants after birth. The person who is identified in the order of custody or relinquishment of custody may sign the discharge documents prior to discharge. In other words, neither an adoption attorney nor adoption agency representative need to be present at the time of discharge.
- G. The adoption coordinator shall place the discharge authorization on the chart along with the order of custody or the relinquishment of custody.
- H. Discharge instructions shall be provided to the prospective adoptive parent(s) if they are at the hospital at the time of discharge or to the adoption facilitator who is present at the time of discharge.
- I. The samples and gift packs normally provided to a mother who gives birth at the hospital shall be provided to the prospective adoptive parent(s) or adoption facilitator.
- J. Photographs of the infant may be ordered by the prospective adoptive parent(s) or the adoption facilitator.
- K. The adoption coordinator shall see that arrangement for the payment of hospital expenses are made in accordance with the Billing Section of these guidelines.
- L. Assuming that the appropriate HIPAA release has been signed by the

mother, the adoption facilitator or the prospective adoptive parent(s) shall be given a copy of the infant's hospital records, which are available, at the time of discharge. Since it is unlikely that the doctor who will care for the infant after discharge is the same doctor who cared for the infant in the hospital, it is important for the infant's continuity of care that medical records be supplied at the time of discharge.

## **VI. BILLING**

- A. The adoption coordinator shall ask the adoption facilitator whether the adoption facilitator, the prospective adoptive parent(s), or the mother is responsible for the medical expenses and then direct the appropriate party to the patient accounts office of the hospital at the time of discharge. Typically, in adoptions, the adoption facilitator or the adoptive parent(s) assume responsibility for the medical expenses for the mother and infant to the extent that those expenses are not covered by Medicaid or insurance.
- B. If the mother has Medicaid or private insurance, the hospital should bill Medicaid or the private insurance for her charges, unless
  1. the adoption facilitator or the adoptive parent(s) have agreed to pay the medical expenses without regard to Medicaid or private insurance or
  - 2.. for reasons of confidentiality, the mother does not want Medicaid or her private insurance to be billed and the prospective adoptive parent or adoption facilitator have agreed to pay the medical expenses.
- C. If the mother has Medicaid, the hospital should have the infant enrolled in Medicaid. The Program Policy Manual ( "PPM") published by the Indiana Family and Social Services Administration, generally provides that if the birth mother of a child has Medicaid or Hoosier Healthwise, the child is automatically eligible for period of time, even if the child is adopted. See

PPM 2225.10.00<sup>c</sup> and 2428.00.00<sup>d</sup>.

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<sup>c</sup> 2225.10.00 ADDING A NEWBORN CHILD (MED)

An infant born alive to a woman enrolled in any MA category except MA10 is deemed eligible for Medicaid without an application for the infant being submitted. The baby is to be immediately added to ICES upon the agency receiving notification of the birth. Refer to Section 2428.00 for more information regarding eligibility in the Newborn category.

Health coverage under the Newborn category is effective the first day of the month in which the child is born and continues for 12 consecutive months. The only allowable reasons to discontinue MA before the end of the 12-month Newborn period are 1) the child no longer lives in Indiana, 2) the child's parent or caretaker provides a written voluntary withdrawal statement, or 3) the child dies. Newborn coverage continues regardless of whether the infant continues to live with the birth mother or whether the child ever lived with the birth mother in the case of adoption or other custody arrangement. However, if the child is adopted and the names and location of the adoptive parent(s) are unknown, the child can only be covered for the duration of the hospitalization starting with the month of birth. If the infant has not been named, the name assigned to her/him by the hospital for identification purposes, should be used.

Information sufficient to enroll the infant in the Newborn category is the child's name, sex, and date of birth. Birth notification may be made by the parent; however, notification is also to be accepted from the hospital, authorized representative in the case, medical provider or Hoosier Healthwise health plan that who can knowingly provide the required information.

When the 12-month Newborn coverage period expires, eligibility under other medical categories must be explored and verified. The child was deemed to have applied at birth, and therefore an application cannot be required in pursuing a category change.

Newborn coverage does not extend to babies born to mothers covered under the MA 10 category - Hoosier Healthwise Package C. However upon request by the parent/caretaker or other notification of the birth, an application is to be immediately provided or mailed to the family, or information given about obtaining an application from the internet. Hospitals and other Indiana Medical Providers that are Hoosier Healthwise enrollment centers should be encouraged to take the applications for newborns. They will know the eligibility status of the mother by using their Eligibility Verification System, which will indicate the benefit package of the mother.

<sup>d</sup> 2428.00.00 NEWBORN STATUS (MED)

The policy stated in this section only applies to the MA X category [***Editor's Note: MA X is Newborn category***].

- D. If Medicaid or private insurance is not available, the patient accounts office shall make arrangements with the person who has assumed responsibility for the payment of the medical expenses prior to the discharge of the infant. The person who has agreed to pay the medical expenses shall be afforded the same payment arrangements as any other patient who incurs charges without having Medicaid or private insurance.
- E. Whether or not the infant is, or will be, covered by Medicaid, the hospital should direct bill the prospective adoptive parent(s)' insurance for the infant's charges whenever possible. Medicaid is always secondarily responsible. In other words, private insurance must be billed before Medicaid will make payment. Neither the adoption facilitator nor the prospective adoptive parent(s) should be asked to guarantee payment of the infant's charges. That could disqualify the infant from coverage under Medicaid.
- F. Additionally, whomever has assumed responsibility for the payment of the medical expenses shall sign whatever other documents regarding financial responsibility which the hospital would have signed in the case any other delivery at the hospital.

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A child born to a woman, who is eligible for traditional Indiana Medicaid or Hoosier Healthwise under any benefit package except Package C (MA 10), on the date the child is born, is eligible for 12 continuous months as long as the child continues to live in Indiana. This also includes infants born to mothers who are eligible for emergency Medicaid services only. (f80) An application is not required and the only eligibility factor at the time of the birth is that the infant's birth mother was eligible for Medicaid when the infant was born. The 12-month eligibility period will end before the 12th month only due to loss of Indiana residency, a written voluntary withdrawal from the caretaker/parent, or death of the child. Refer to Section 2225.10.00 for case processing information and information about adding a newborn to the case. The newborn must be enrolled in Medicaid without delay.

As long as the mother is determined eligible for Medicaid/Hoosier Healthwise for the month of the child's birth, the child is eligible in the Newborn category even when the mother applies for Medicaid after the child is born. If the child is born during a month of the mother's retroactive coverage and she is eligible for that month, the baby is eligible for the Newborn category.

Coverage in the Newborn category continues for the 12 month period if the child goes to live with someone other than the birth mother, including adoption when the child leaves the hospital and goes directly to live with the adoptive parent(s). However, if the identity and location of the adoptive parent(s) are not known, or the child is adopted by parents living out of state, benefits under the Newborn category are provided for the birth month through discharge and removed the subsequent month. If the infant has not been named, the name assigned to the child by the hospital for identification purposes may be used. If the child is adopted to parents living out of state, newborn coverage in Indiana is approved for the birth month only.

## **VII. MEDICAL RECORDS AND CHARTING**

- A. Upon the presentment of a properly executed authorization to release medical information (Forms 5a and 5b), the hospital may release medical information for the mother or infant, or both, to whomever is authorized in the medical information release form(s) to receive the medical information.
- B. The medical information release form used by the hospital for the release of medical information in other circumstances may be used for release of medical information in an adoption.
- C. As long as the following provisions are contained in a medical information release form, medical information may be released, even if the standard hospital medical information release form is not executed and presented to the hospital:
  - 1. Core Elements:
    - a. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
    - b. The name or other specific identification of the person(s), or class of persons, authorized to make the requested disclosure.
    - c. The name or other specific identification of the person(s), or class of persons, to whom the hospital may make the requested disclosure.
    - d. A description of each purpose of the requested disclosure. The statement "at the request of the Individual" is a sufficient description of the purpose when an Individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
    - e. An expiration date or an expiration event that relates to the Individual or the purpose of the disclosure.
    - f. Signature of the Individual and date. If the authorization is signed by a personal representative of the Individual, a description of such representative's authority to act for the Individual must also be provided. Indiana: address of individual must also be included
  - 2. Required Statements. In addition to the core elements, the authorization must contain statements adequate to place the Individual on notice of all of the following:

- a. The Individual's right to revoke the authorization in writing, and the exceptions (reliance on a signed authorization) to the right to revoke and a description of how the Individual may revoke the authorization;
  - b. The hospital may not condition treatment or payment on whether the Individual signs the authorization;
  - c. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by the HIPAA Privacy Regulations.
- D. If the adoption facilitator requests the mother or infant's medical information, or both, and the medical chart has not already been sent to the medical records department of the hospital, the adoption coordinator or the charge nurse may copy the requested information and give them to the adoption facilitator upon presentment of a properly executed medical information release form, which shall be copied and inserted in the chart(s) copied. This is particularly important in the case of an interstate adoption. Without the hospital records, the adoption attorney or agency cannot begin the process of obtaining compliance with the Interstate Compact on the Placement of Children ("ICPC"). Without compliance with the ICPC, the prospective adoptive parent(s) cannot return to their home state with the infant. Therefore, time is of the essence in getting the medical records to the adoption attorney or agency.
- E. It is not necessary to remove identifying information from the medical information before releasing medical information to the adoption facilitator.
- F. Care should be taken not to include any of the prospective adoptive parent(s)' identifying information in the mother's medical records other than their first names, because she will have access to those records indefinitely.
- G. The infant's chart should be flagged as being an adoption. The mother shall not have access to the infant's medical records after she signs a consent to adoption, consent to termination, or relinquishment of custody. Information may be released to the adoption facilitator upon presentment of a properly executed HIPAA release. Flagging the chart will help prevent inadvertent disclosure of information in the future.

## **VIII. GENERAL INFORMATION ABOUT ADOPTION**

- A. Interstate Adoptions
  - 1. Adoptions between states require compliance with the Interstate Compact on the Placement of Children ("ICPC"). In order to comply with the ICPC, the adoption attorney or agency must supply

documentation to the ICPC office of both the sending and receiving states. The infant cannot be taken across state lines without the approval of ICPC offices of both states.

2. The significance of the ICPC as it relates to adoptions at the hospital is that prospective adoptive parent(s) cannot leave the state without approval of the ICPC offices of both states. If the adoption coordinator becomes aware that prospective adoptive parent(s) do not intend on complying with the ICPC, the adoption coordinator shall immediately contact \_\_\_\_\_. **[Note:** The contact will vary from hospital to hospital but may include hospital administration, risk management, legal department, and etc.]

#### B. Birth Fathers

1. The rights of the father vary depending upon his relationship with the mother and range from a rapist, who has no rights, to a husband whose rights are equal to the mother (so long as he is the biological father of the child).
2. A “legal” father is a man who is married to the mother or who has established paternity of the child by executing a paternity affidavit or through court action. A “putative” father is every other man. The parental rights of a man who has established paternity are the same as a husband (who is the biological father of the child).
3. As a general rule, and nearly always true in the hospital setting, an infant cannot be adopted without the consent of a legal father. Therefore, it is essential that hospital staff **not** have a man in attendance at, or after, the birth sign a paternity affidavit without first consulting with the adoption facilitator. A man who signs a paternity affidavit acquires a veto over the adoption by simply withholding, or not being available to give, his consent. That may be contrary to the wishes of the birth mother and she may not be aware of the consequences of a putative father signing a paternity affidavit and then failing to be available at the time of the consent signing.
4. Indiana Code § 31-19-5-14 requires that hospitals post in a conspicuous place information about the Putative Father Registry administered by the State Department of Health (“SDH”). The SDH has posters available which satisfy the statutory requirements. The poster must be displayed in the OB, Birthing or Family Life Center of the hospital.

- C. “Safe Haven Law”. Indiana Code § 31-34-2.5 allows a parent to anonymously leave a child who is not more than thirty days of age with an “emergency medical services provider”, which includes a firefighter, law enforcement officer, paramedic, emergency medical technician, medical

doctor, nurse, or other person who routinely provides emergency medical services<sup>e</sup>), If an infant is left with an emergency medical services provider, the department of child services shall assume custody of the infant but the department is not required to locate the infant's parents or attempt to reunite the infant with the infant's family.

1. As a last resort, a mother may invoke the Safe Haven Law if she is not able to properly care for the infant and an adoption plan is not possible.
2. The adoption coordinator shall fully explore adoption with the mother and consult an adoption facilitator before suggesting the Safe Haven Law. **For the purposes of consulting with an adoption facilitator, Steven M. Kirsh, a co-author of these guidelines is an expert on adoption law and is available to help the adoption coordinator analyze if the mother has any options short of invoking the Safe Haven Law.**

## IX. FORMS

- A. Form 1 - **Birth Mother Request Form**. On this form the mother will express requests for her care in the hospital. The hospital should try to accommodate her requests, subject to the approval of the attending physician, to the extent reasonably possible. Authorizations to Release Medical Information have been attached to this form to comply with HIPAA.
- B. Form 2 - **Discharge Authorization**. Prior to discharge of the infant, the mother shall sign this form. When the infant is discharged from the hospital, the person assuming custody of the child from the hospital shall sign the bottom half of the form acknowledging receipt of custody of the infant.
- C. Form 3 - **Infant Care Authorization**. The mother shall sign this form if the mother requests that the prospective adoptive parent(s) care for, and have contact with, the infant prior to the receipt by the hospital of a court order authorizing discharge of the infant.
- D. Form 4 - **Authorization for Treatment of Newborn**. The mother shall sign this form if she will be discharged from the hospital prior to the receipt by the hospital of a court order authorizing the discharge of the infant.
- E. Form 5a – **Authorization to Release Medical Information (Mother's Information)**. A separate form is required for the mother and infant. The mother signs both forms.
- F. Form 5b – **Authorization to Release Medical Information (Infant's Information)**. A separate form is required for the mother and infant. The

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<sup>e</sup> Indiana Code § 16-41-10-1 defines "emergency medical services provider".

mother signs both forms.

- G. Form 6 – **Attendance Request Authorization**. Prior to, or after admission to the hospital the mother may sign this form allowing the prospective adoptive parent(s) to be present at the hospital. Use of this form eliminates the need to hide the mother’s identifying information from the prospective adoptive parent(s) and “reband” the infant.
- H. Form 7 -- **Authorization to Bill Adoptive parent(s)’ Insurance**
- I. Form 8 – **Checklist for Adoptions\**

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October 23, 2014

## FORM 1

### BIRTH MOTHER REQUESTS FOR HER HOSPITAL CARE

BIRTH MOTHER'S NAME: \_\_\_\_\_

BIRTH MOTHER'S SOCIAL SECURITY NO: \_\_\_\_\_

BIRTH MOTHER'S DATE OF BIRTH: \_\_\_\_\_

EXPECTED DELIVERY DATE: \_\_\_\_\_

BIRTH MOTHER'S PHYSICIAN: \_\_\_\_\_

**BIRTH MOTHER'S WISHES:** *[The birth mother has the right to change these requests. Please try to accommodate her wishes to the extent possible, subject, of course, to the approval of the attending physicians and applicable hospital policies.]*

1.	Would you like to see the baby?	Yes No Undecided
2.	Would you like to know the sex of the baby?	Yes No Undecided
3.	Would you like to care for the baby in the hospital?	Yes No Undecided
4.	Would you like to be moved off the maternity floor?	Yes No Undecided
5.	Would you like a private room, if available?	Yes No Undecided
6.	Would you consent to circumcision, if the adoptive parent(s) would like to have the baby circumcised?  <b><u>NOTES TO HOSPITAL STAFF:</u></b> <i>(A) If she chooses not to know the sex of the baby, please have a consent to circumcision signed before birth, if possible, to avoid inadvertent disclosure of baby's sex, and (B) even if the</i>	Yes No Undecided

	<b><i>birth mother requests a circumcision, please do not circumcise the baby until confirmation from us is received that the adoptive parent(s) would like the baby circumcised.</i></b>	
7.	Would you like your hospital stay kept totally confidential? (In any case, the hospital may release information to _____ (adoption facilitator.)	Yes No Undecided

8. She would like the following persons in labor and delivery with her:

\_\_\_\_\_

9. She would like the following persons to be allowed to see the baby in the hospital:

- \_\_\_\_\_ Anyone to whom she gives permission at the hospital  
 \_\_\_\_\_ No one may see the baby

10. She would like for \_\_\_\_\_ (adoption facilitator) to be contacted upon her being admitted in labor and also after the baby is born.

11. She hereby authorizes the hospital and attending physicians to release information, including results of HIV testing, either in writing or by telephone, or both, about her and the baby pursuant to the attached authorizations to release medical information.

13. Other requests: \_\_\_\_\_

\_\_\_\_\_

**ADOPTION FACILITATOR CONTACT:** (Please contact with any questions or concerns):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand that this is not a consent to adoption and that by signing this form I am not under any obligation to proceed with an adoption. I hope that the hospital will accommodate my wishes, as expressed on this form, to the extent reasonably possible.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Birth Mother's Signature

Witness: \_\_\_\_\_

**{Attached to Form 1}**  
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
**Pursuant to HIPAA**  
**(Mother's Information)**

TO: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Dates of Treatment: from \_\_\_\_\_ to \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, the undersigned, hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, me (collectively referred to as "**Health Care Providers**") to disclose to the following individuals and entities ("**Recipients**"), and **Recipients**, to thereafter disclose my health information as follows: Any and all medical, general, psychological, psychiatric, membership, and/or health information pertaining to me which is now or in the future may be in the possession or under the control of **Health Care Providers** including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). **Recipients** may disclose this information to the following person(s) or organization(s):

Attorney(s) for adoptive or birth parents	Adoptive parent(s)
Agency for adoptive parent(s)	Court in connection with adoption
Interstate Compact on the Placement of Children	County or State Public Adoption Agencies
Native American Nations or Tribes/Alaska Native Villages	

Other persons or entities deemed necessary by **Recipients** to facilitate the adoption of my child(ren)  
Physicians and other health care professionals consulted by any of these individuals and entities

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indiana Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the **Health Care Providers**. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. **This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child(ren) born or to be born.**

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

_____ Witness	_____ Signature of Parent/Patient
Date: _____	_____ Signature of Other Authorized Person/Relationship

**{Attached to Form 1}**

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

**Pursuant to HIPAA**  
**(Infant's Information)**

TO: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Dates of Treatment: from \_\_\_\_\_ to \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, the undersigned, on behalf of my child born, or to be born on or about, \_\_\_\_\_, hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, my child (collectively referred to as "**Health Care Providers**") to disclose to the following individuals and entities ("**Recipients**"), and for **Recipients**, to thereafter disclose my child's health information as follows: Any and all medical, general, psychological, psychiatric, membership, and/or health information pertaining to me which is now or in the future may be in the possession or under the control of **Health Care Providers** including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). "**Recipients**" are defined as, and may disclose this information to, the following person(s) or organization(s):

Attorney(s) for adoptive or birth parents	Adoptive parent(s)
Agency for adoptive parent(s)	Court in connection with adoption
Interstate Compact on the Placement of Children	County or State Public Adoption Agencies
Native American Nations or Tribes/Alaska Native Villages	

Other persons or entities deemed necessary by **Recipients** to facilitate the adoption of my child(ren)  
Physicians and other health care professionals consulted by any of these individuals and entities

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indiana Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the **Health Care Providers**. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. **This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child born or to be born.**

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

_____ Witness	_____ Signature of Parent/Patient
Date: _____	_____ Signature of Other Authorized Person/Relationship

**FORM 2**  
**DISCHARGE AUTHORIZATION**

Name of Infant: \_\_\_\_\_ or Infant Male/Female \_\_\_\_\_  
Infant's Date of Birth: \_\_\_\_\_  
Name of Birth Mother: \_\_\_\_\_  
Reason for Discharging Infant to Another: Adoption or specify other reason:

PERSON(S) TO WHOM INFANT WILL BE DISCHARGED (SELECT ONE):

\_\_\_\_\_ THE "ADOPTION FACILITATOR" IDENTIFIED AS \_\_\_\_\_, OR  
\_\_\_\_\_ DIRECTLY TO THE CUSTODY OF THE PROSPECTIVE ADOPTIVE PARENT(S) AS  
IDENTIFIED IN THE ORDER OF CUSTODY TO BE ISSUED BY THE  
\_\_\_\_\_ COURT, \_\_\_\_\_ COUNTY, INDIANA.

The undersigned, birth mother of the infant identified above, authorize(s) and direct(s) \_\_\_\_\_ Hospital to discharge the infant to the custody of the above identified person(s). The undersigned represent(s) that this decision is being made as a free and voluntary act after careful deliberation, and that the signing of this authorization is not being done under compulsion, duress or undue influence. The undersigned further understand(s) that the hospital has made no investigation or determination of the background of the person(s) to whom the infant will be discharged and has not participated in any manner in the undersigned's decision to discharge the infant to above named persons; and accordingly, the hospital has no opinion or recommendation regarding the persons to whom the infant will be discharged.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Birth Mother's Signature

WITNESS: \_\_\_\_\_

**RECEIPT OF CUSTODY OF INFANT**

The undersigned hereby acknowledges receipt of custody of \_\_\_\_\_ (name of infant)  
or Infant Male/Female \_\_\_\_\_ on this \_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Title/Position: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**FORM 3**

**AUTHORIZATION ALLOWING PROSPECTIVE  
ADOPTIVE PARENT(S) TO CARE FOR NEWBORN**

\_\_\_\_\_ (birth mother's name) hereby authorizes \_\_\_\_\_  
(name of hospital) (the "hospital") to allow \_\_\_\_\_ and \_\_\_\_\_  
(first names of prospective adoptive parent(s)) to have physical, including skin-to-skin, contact with the  
baby to whom I gave birth on \_\_\_\_\_, 20\_\_\_\_ (child's date of birth), including the  
opportunity to feed, change, hold, and generally care for the baby while the baby is still in the hospital.

It is my intention that the prospective adoptive parent(s) have as much contact with, and have the  
same rights to care for, the baby as I. In giving this authorization, I understand that the prospective  
adoptive parent(s) will have access to identifying and medical information about the infant and me. I  
hereby release the hospital and all medical providers from any and all liability arising from any such  
disclosure of information.

In giving this authorization, I am not relinquishing my rights to care for the baby. I would still like  
to be able to spend time with, and care for, the baby while I am still in the hospital, if I so desire.  
However, at any time when I am not taking care of the baby, I would like for the prospective adoptive  
parent(s) to be able to do so.

It is not necessary for me to be present while the prospective adoptive parent(s) are caring for the  
baby.

This Authorization is not a consent to adoption. I understand that I will sign, if I have not already  
signed, a separate consent to the adoption of the baby.

I hereby release and discharge the hospital from any and all liability of whatsoever nature and  
howsoever arising out of my having given this Authorization to the prospective adoptive parent(s).

Finally, I understand that I may revoke this Authorization at any time prior to my signing a consent  
to adoption by writing the words, "I revoke this authorization", across the bottom of this document and  
then signing my name underneath those words.

DATED: \_\_\_\_\_ BIRTH MOTHER'S SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**FORM 4**

**AUTHORIZATION FOR TREATMENT OF NEWBORN**

**BIRTH MOTHER'S NAME:** \_\_\_\_\_

**CHILD'S DATE OF BIRTH:** \_\_\_\_\_

I, \_\_\_\_\_, hereby state:

1. I am the mother of a \_\_\_\_\_ (MALE-FEMALE) infant born on \_\_\_\_\_, (the "Child") at \_\_\_\_\_.

2. I have given my written consent to adoption on \_\_\_\_\_.

3. I understand that within the next day or so, the \_\_\_\_\_, \_\_\_\_\_,

will issue an order granting the prospective adoptive parent(s) custody of the Child.

4. Pursuant to Indiana Code § 16-36-1, The Health Care Consent Act (the "Act"), between now and the time that the court issues an order granting the prospective adoptive parent(s) custody of the Child, I hereby delegate authority to \_\_\_\_\_ (adoption facilitator), or both, to make all decisions and to obtain necessary "health care" as those words are defined in the Act on behalf of the Child.

5. I hereby further authorize \_\_\_\_\_ (adoption facilitator), or both, to delegate the authority which I have granted in this Authorization for Treatment to the prospective adoptive parent(s).

6. I hereby consent to health care being obtained by \_\_\_\_\_ (adoption facilitator), or both, and by the prospective adoptive parent(s), if a further delegation or authority is made.

7. Without in any manner limiting the applicability of Indiana Code § 16-36-1-

10, I hereby release \_\_\_\_\_,  
and its officers, directors, employees, doctors, successors and assigns;  
\_\_\_\_\_(adoption facilitator), and their employees, successors, and  
assigns; and the prospective adoptive parent(s), and their successors and assigns, from  
any and all liability of whatsoever nature arising out of the care and treatment provided  
to the Child in accordance with this Authorization.

DATED: \_\_\_\_\_ BIRTH MOTHER'S SIGNATURE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

The undersigned hereby delegates the authority granted in this Authorization to  
\_\_\_\_\_ and \_\_\_\_\_ (the prospective adoptive  
parent(s)) as of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Adoption Facilitator

WITNESS: \_\_\_\_\_

**FORM 5a**  
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
**Pursuant to HIPAA**  
**(Mother's Information)**

TO: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Dates of Treatment: from \_\_\_\_\_ to \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, the undersigned, hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, me (collectively referred to as "**Health Care Providers**") to disclose to the following individuals and entities ("**Recipients**"), and **Recipients**, to thereafter disclose my health information as follows: Any and all medical, general, psychological, psychiatric, membership, and/or health information pertaining to me which is now or in the future may be in the possession or under the control of **Health Care Providers** including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). **Recipients** may disclose this information to the following person(s) or organization(s):

Attorney(s) for adoptive or birth parents	Adoptive parent(s)
Agency for adoptive parent(s)	Court in connection with adoption
Interstate Compact on the Placement of Children	County or State Public Adoption Agencies
Native American Nations or Tribes/Alaska Native Villages	

Other persons or entities deemed necessary by **Recipients** to facilitate the adoption of my child(ren)  
 Physicians and other health care professionals consulted by any of these individuals and entities

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indiana Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the **Health Care Providers**. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. **This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child(ren) born or to be born.**

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

Witness	Signature of Parent/Patient
Date: _____	Signature of Other Authorized Person/Relationship

**FORM 5b**  
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
**Pursuant to HIPAA**  
**(Infant's Information)**

TO: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Dates of Treatment: from \_\_\_\_\_ to \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, the undersigned, on behalf of my child born, or to be born on or about, \_\_\_\_\_, hereby authorize the above-named health care provider, all physicians, hospitals, and other health care professionals who provide care to, or consult in the care of, my child (collectively referred to as "**Health Care Providers**") to disclose to the following individuals and entities ("**Recipients**"), and for **Recipients**, to thereafter disclose my child's health information as follows: Any and all medical, general, psychological, psychiatric, membership, and/or health information pertaining to me which is now or in the future may be in the possession or under the control of **Health Care Providers** including specifically, and without limitation, the results of any and/or all autoimmune deficiency (HIV/AIDS) testing, drug, alcohol, sexually transmitted disease, Hepatitis A, B, and C, and Herpes tests. I understand that this information may include information relating to sexually transmitted diseases, Human immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex), and other communicable diseases. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CRF Part 2). "**Recipients**" are defined as, and may disclose this information to, the following person(s) or organization(s):

Attorney(s) for adoptive or birth parents	Adoptive parent(s)
Agency for adoptive parent(s)	Court in connection with adoption
Interstate Compact on the Placement of Children	County or State Public Adoption Agencies
Native American Nations or Tribes/Alaska Native Villages	

Other persons or entities deemed necessary by **Recipients** to facilitate the adoption of my child(ren)  
Physicians and other health care professionals consulted by any of these individuals and entities

This disclosure and use is for the following purposes: Adoption, custody, guardianship, parental rights matters, Indiana Child Welfare Act inquiries, and ICWA and ICPC clearances.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department of the **Health Care Providers**. Unless otherwise revoked, this authorization will expire eighteen months from the signature date. I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits. **This document also authorizes any Native American tribe, Indian tribe or Alaska Native Village to release information about the membership status or eligibility for membership of myself or my child born or to be born.**

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photocopy of this authorization shall be deemed as valid as the original for all purposes.

Witness	Signature of Parent/Patient
Date: _____	Signature of Other Authorized Person/Relationship

**Form 6**  
**Attendance Request Authorization**

\_\_\_\_\_ (birth mother's name) hereby authorizes \_\_\_\_\_  
(name of hospital) (the "hospital") to allow \_\_\_\_\_ and \_\_\_\_\_  
(first names of prospective adoptive parent(s)) to be present at the hospital with child and me in  
my room, the nursery, a room set aside for them, and any other place deemed appropriate by  
the hospital. In giving this authorization, I understand that the prospective adoptive parent(s) will  
have access to identifying and medical information about the infant and me. I hereby release  
the hospital and all medical providers from any and all liability arising from any such disclosure  
of information.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Mother's name

\_\_\_\_\_  
Witness

**Form 7**  
**Authorization to Bill Adoptive Parent's(s) Insurance**

The undersigned hereby specifically authorizes \_\_\_\_\_ (name of hospital) and any health care provider which has provided care to the child to whom I gave birth on \_\_\_\_\_, to bill the prospective adoptive parent's(s) insurance directly for any medical expenses incurred on behalf of the child. In giving this authorization, I understand that identifying information may be inadvertently shared with the adoptive parent(s) or their insurance company, or both. I hereby waive confidentiality for the limited purpose of allowing their insurance to be billed directly.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Mother's name

\_\_\_\_\_  
Witness

## Form 8

### Checklist for Adoptions

#### Admissions into Labor

- Confirm that mother is still considering adoption
- Complete Hospital Request Form (Form 1), if not already completed
- Have mother sign:
  - HIPAA release to provide information to adoption facilitator for infant (Form 5b) and her (Form 5a)
    - Place mother's release on her chart
    - Place infant's release on infant's chart
  - Attendance Request Form (Form 6) if she would like prospective adoptive parents with her in labor and delivery
  - Infant Care Authorization (Form 3) if she would like the prospective adoptive parents to be able to care for the infant
  - Circumcision consent if she does NOT want to know the sex of the infant
- Contact adoption facilitator to inform that mother has been admitted into labor

#### After Birth

- Confirm that mother is still considering adoption
- Coordinate consent signing time with adoption facilitator
- Paternity affidavit signed **ONLY AFTER** consent to adoption/termination is signed
- Complete birth certificate application
- Mother to sign:
  - Consent to adoption/termination or relinquishment to agency
  - Authorization for Treatment (Form 4)
  - Discharge Authorization (Form 2)
  - HIPAA release for her records (Form 5a) [**unless already signed**]
  - HIPAA release for infant's records (Form 5b) [**unless already signed**]
  - Authorization to Bill Adoptive Parents' Insurance (Form 7)

#### Discharge

- Coordinate discharge arrangements with the prospective adoptive parents or adoption facilitator
- Place court order for custody on infant's chart
- Verify identity of infant and persons named in the court order of custody
- Have person identified in the court order of custody sign the bottom of the Discharge Authorization (Form 2) acknowledging receipt of custody of infant
- Provide discharge instructions to prospective adoptive parents
- Confirm that financial arrangements have been made for the payment of hospital/doctor charges with the prospective adoptive parents