**CLARK COUNTY CONSENT FOR RELEASE OF INFORMATION**

Please send this information to:

**Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Attn:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME:** **DOB**: **SSN#**:

**\*Use a separate Release for each adult or child for whom information is requested.**

**WORKER/AGENCY:**

**I, on behalf of myself, or as the parent, legal guardian or custodian of the above-named individual, do hereby authorize and direct the following organization(s) I have identified with my initials:**

**\_\_\_\_** Aetna \_\_\_\_\_Family Youth Initiatives FYI

**\_\_\_\_** CASA/ GAL/ Attorney \_\_\_\_\_ Law Enforcement/Prosecutor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Catholic Social Services \_\_\_\_\_ Mental Health Services \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Children’s Medical Facility \_\_\_\_\_ Mental Health Recovery Board of Clark, Greene & Madison Co.

\_\_\_\_\_ Dayton Children’s \_\_\_\_\_ Mercy Reach

\_\_\_\_\_ Cincinnati Children’s \_\_\_\_\_ Miami Valley Child Development Centers

\_\_\_\_\_ Nationwide Children’s \_\_\_\_\_ NYAP (National Youth Advocate Program – CME)

\_\_\_\_ Child Advocacy Center \_\_\_\_\_ Oesterlen

\_\_\_\_ CitiLookout \_\_\_\_\_ OhioRISE

\_\_\_\_\_ Pediatric Associates

\_\_\_\_ Clark Co. Dept. of Job & Family Svcs. \_\_\_\_\_ Other Pediatrician /Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Benefits Plus \_\_\_\_\_ Project Woman

\_\_\_\_\_ Ohio Means Jobs \_\_\_\_\_ Restpoint

\_\_\_\_\_ Child Support Enforcement (CSE) \_\_\_\_\_ Rocking Horse Community Health Center

\_\_\_\_\_ Family & Children Services (FCS) \_\_\_\_\_ Salvation Army

\_\_\_\_ Clark Co. Family & Children First Council (FCFC) \_\_\_\_\_ Social Security Administration

\_\_\_\_ Clark Co. FST /MDT Committee & Attendees \_\_\_\_\_ Springfield Regional Medical Center

\_\_\_\_ Clark Co. FCFC IRC Committee & Attendees \_\_\_\_\_ Virtual Meetings

\_\_\_\_ Clark Co. Juvenile Court \_\_\_\_\_ WellSpring

\_\_\_\_ Developmental Disabilities of Clark Co.

\_\_\_\_\_ Opportunities for Ohioans w Disabilities (OOD)

\_\_\_\_ Drug & Alcohol Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Educational Institution (address, fax/email attached)

\_\_\_\_\_ Clark Co. Educational Service Center (ESC) \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Springfield City School District

\_\_\_\_ Encompass \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Faith Based Org. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To release written and verbal communication permitted with my initials:**

**\_\_\_\_** Discharge/Termination Summary \_\_\_\_\_ Physical Assessments/ Medications

\_\_\_\_ Academic plans, Grades, Conduct, Attendance \_\_\_\_\_ Progress Reports/ Case Review Information

\_\_\_\_ Clinical/ Psychological Assessment(s) \_\_\_\_\_ Service/ Treatment Case Plan (s)

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information said organization(s) have in their notes or files concerning the above-named individual’s involvement with above-initialed organization(s) dated from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_ will be used for the purpose of investigation, treatment, management of the case, data and survey collection, or the processing of payment of claims. **No Mental Health and/or Chemical Dependency information will be re-released except by the custodial entity (parent, guardian, custodian, or custodial agency).**

**IMPORTANT INFORMATION- PLEASE READ BEFORE SIGNING**

*This Consent for Release of Information will be applicable to information requested and disclosed under both the Health Insurance Portability and Accountability Act (****HIPAA)*** *and all applicable Federal regulations made under HIPAA, and the Family Education Rights and Privacy Act* ***(FERPA)*** *and all applicable Federal regulations made under* ***FERPA. Furthermore, I hereby authorize and direct that any organization(s) I have identified with my initials may cross release verbal information with any other organization(s) so identified with my initials.*** *I understand that signing this release is voluntary and it does not need to be signed in order for me to receive treatment. I also understand that there is the potential that any information disclosed as a result of this Consent (to which* ***HIPAA*** *may be applicable) may be subject to re-disclosure by anyone who receives the disclosed information and that because of this, such information may no longer be protected under* ***HIPAA****.*

|  |
| --- |
| This consent is subject to revocation in writing at any time except for information already gathered in good faith. If I should revoke my Consent for Release of Information, the revocation does not include any information which has been shared between the time that I gave permission and the time that it was cancelled or any other information to the extent that the relevant agency or entity has taken action in reliance on this Consent for Release of Information.  **This authorization (consent for release of information) will remain effective** **for** **90 or 180 days (circle one) unless an earlier date is specified here \_\_\_\_\_\_\_\_\_\_\_.**  I understand that the agencies receiving this information must hold it as confidential and may not further release it to any other person or agency not identified by my initials, unless specifically authorized to do so. Information will only be shared to the extent necessary to achieve the goals of investigation, treatment, management of the case, or the processing of payment of claims. |

|  |
| --- |
| **Required Notifications Under FERPA** |

|  |
| --- |
| If a parent of a child who signs consent to disclosure of information (this Consent for Release of Information) under ***FERPA*** so requests, the educational agency (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) shall provide him or her with a copy of the records disclosed. If so requested, the educational agency shall also provide a copy of the records disclosed to the student/child who is the subject of the consent to disclosure of information.  Personally identifiable information protected by ***FERPA*** is specifically exempted from ***HIPAA*** privacy standards. ***FERPA*** prevents the disclosure of personally identifiable information without parental l consent except in limited circumstances, requires notice to be provided to the child’s family regarding their privacy rights, requires providers to keep records of access to the child’s records, and contains complaints and appeal procedures which apply to disputes over records to which ***FERPA*** is applicable.  **Chemical Dependency Programs**:  When/if you agree to any release of your health information, the following statement is stamped on all released documents per Federal Regulations: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. |

|  |
| --- |
| **HIV Release**:  This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for the purpose of the release of ***HIV*** test results or diagnoses.  **Data System Release:**  By signing this form, you are consenting to allow personal information to be entered into two (2) web-based data portals maintained by the State of Ohio, specifically Ohio Dept. of Job and Family Services (ODJFS) and Ohio Dept. of Medicaid (ODM).  ODJFS and ODM ensure that all information entered meets federal and state confidentiality and security requirements and takes action to mitigate any reasonable risks and hazards. Further, ODJFS and ODM protect against all unauthorized disclosures and manages compliance for all employees, contractors and vendors. |

|  |  |
| --- | --- |
| **Client Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (age 12 and over) | |
| **Print Name**: | Date: |
| **Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Print Name**: | Date: |
| **Witness Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Print Name**: | Date: |
| **This release expires on: Date cannot be more than 180 days from today’s date.** | |
| I hereby revoke consent: Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Staff/Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Revised: 6.14.22** | |