CONSENT FOR RELEASE OF INFORMATION

Child/Youth's Full Name:_____ Date: _____

Date of Birth_____

The following agencies have my permission to exchange/give/receive/share/re-disclose information regarding service delivery planning for the Huron County Family and Children First Council for the purpose of securing, coordinating, and/or providing services for the above named person (please identify any additional agencies to be included):

MEMBER AGENCIES:

- ☐ School District:_____
- ☐ Regional/Local Family Advocates: _____
- ☐ North Point Educational Service Center
- ☐ Fisher Titus Medical Center
- ☐ Huron County Board of MR/DD
- ☐ Reach Our Youth
- ☐ Huron County Mental Health and Addiction Services Board
- ☐ Townsend Community School
- ☐ Huron County Department of Job & Family Services
- ☐ Huron County Family/Juvenile Court
- ☐ Ohio Department of Youth Services
- ☐ Firelands Counseling & Recovery Services
- ☐ Huron County Early Intervention Collaborative/Help Me Grow
- ☐ Huron County Board of Health
- ☐ Community Action Commission of Erie, Huron & Richland Counties
- ☐ Family Life Counseling
- ☐ Family & Children First Council Director/Council
- ☐ Ohio Guidestone
- ☐ Catholic Charities
- ☐ Family Doctor _____

I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual: (Circle yes or no and initial)

Circle One		Initials	
Yes	No	_____	Identifying Information: name, birth date, sex, race, address and telephone number.
Yes	No	_____	Social Security number.
Yes	No	_____	Case Information: the above Identifying Information, plus medical (except for HIV, AIDS, and drug and alcohol treatment records) and

social history, treatment/ service history, psychological evaluations, Individualized Education Plans (IEP's), Individual Family Service Plans, Court and Law Enforcement Records, transition plans, vocational assessments, grades and attendance, and other personal information regarding me or the individual named above (disability, type of services being received and name of agency providing services to me or the individual named above.) Information regarding the following shall not be released unless initialed below:

Yes	No	_____	HIV and AIDS related diagnosis and treatment.
Yes	No	_____	Substance abuse diagnosis and treatment.
Yes	No	_____	Financial Information: Public assistance eligibility and payment information provided for establishing eligibility including but not limited to pay stubs, W2s and tax returns, and other financial information.
Yes	No	_____	Use of Fidelity Electronic Health Records to store case information, including results of CANS (Child and Adolescent Needs and Strengths) assessment.

I understand that the Consent for Release of Information expires 180 days from the date it is signed unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to the HCFCFC Case Manager or designee. The revocation does not include any information, which has been shared between the time that I gave permission to share information and the time that it was canceled.

I understand that my signing or refusing to sign this consent will not affect public benefits or services that I am eligible for.

_____ _____

Signature of Referring Agency Representative Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness/Agency Representative Date

Violation or Federal law and regulations is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1) If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by Federal law.

Federal regulations (41 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

2) If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records 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.

3) The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, DYS in the case of youth records, or applicable federal and/or state law.

Email/mail/fax completed Referral Form and ROI forms to:

Niki Cross, Director
Huron County Family & Children First Council
185 Shady Lane Drive
Norwalk, OH 44857
Phone: (419) 668-8126 ext. 3336
Fax: (419) 668-4738
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