Family & Children FIRST COUNCIL

2020 Addendum B

Informed Consent for Release & Exchange of Information

The purpose of this Release and Exchange of Information is to facilitate the referral to and functions of ☐Defiance or ☐Williams County Family & Children First Council Service Coordination. The functions are detailed in the County Family & Children First Council Service Coordination Mechanism, including but not limited to coordinating, facilitating, teaming, planning, reviewing, allocating resources, evaluating and monitoring case progress.
All grayed areas require parent/legal guardian initials and completion as noted.

Authorization *(List full names and dates of birth mm/dd/yyyy for all household members to be included in this authorization.)*

Parent/Legal Guardian		Date of Birth	
Parent/Legal Guardian		Date of Birth	
Child	Date of Birth	Child	Date of Birth
Child	Date of Birth	Child	Date of Birth
Child	Date of Birth	Child	Date of Birth

I hereby authorize to release or exchange information with the following agencies for the purposes outlined above, as indicated by my initials, which may include protected health information. Only the minimum amount of information needed to achieve the stated purposes may be disclosed.

Initial_____	County Family and Children First Council	Initial_____	Four County ADAMhs Board
Initial_____	County Board of Developmental Disabilities	Initial_____	NW OH Educational Service Center/Independence Education Center
Initial_____	County Health Department	Initial_____	Ohio Department of Youth Services
Initial_____	County Job & Family Services	Initial_____	Referring Agency: _____
Initial_____	County Juvenile Court/CASA Representatives	Initial_____	Medicaid Managed Care Plan: _____
Initial_____	County Juvenile Probation	Initial_____	Other: _____
Initial_____	City/County Schools	Initial_____	Other: _____

Extent of Authorization *(Initial and check yes or no to reflect your understanding and consent to the following.)*

Initial_____ ☐Yes ☐No Release or exchange of case records including identifying information; protected health and medical information (except for HIV, AIDS and alcohol/drug abuse diagnosis and treatment); mental health records such as psychological evaluations, treatment history and service history; social history; education records such as Individual Education Plans (IEP's), transition plans, vocational assessments, grades and attendance; financial information; and other personal information held by any of the above authorized agencies providers regarding the above named individuals.

Initial_____ ☐Yes ☐No Release or exchange of communicable diseases (including HIV and AIDS) records, diagnoses and treatment.

Initial_____ ☐Yes ☐No Release or exchange of alcohol/drug abuse diagnosis and treatment.

Initial_____ ☐Yes ☐No Choice to yes (accept) or no (decline) Parent Advocacy Services, which is a mandatory offer for Service Coordination.

Initial_____ ☐Yes ☐No Choice to use videoconferencing between the County Family & Children First and the above named individuals and agencies. N*ote, third-party video conferencing applications, such as Zoom, potentially introduce privacy risks.*

Initial_____ ☐Yes ☐No A protected, cloud-based electronic health record data system will be used to collect and analyze data on youth/families served through Service Coordination. All reports and publications of findings related to the evaluation of Service Coordination services received will not reveal any names; all information and results will be presented in group format.

I understand I am under no obligation to sign this authorization form. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the information described. The information released is for professional purposes only. Information may not be provided in whole or in part to any other agency, organization or person other than those stated above. I understand the County Family & Children First Council cannot guarantee the recipient will not disclose my health information to a third party, and that the recipient may not be subject to Federal laws governing privacy of health information. However, if the disclosure consists of treatment information about alcohol or drug abuse treatment, the recipient is prohibited from re-disclosure under federal law (42 CFR Part 2).

I understand I have 1) the right to revoke or cancel this authorization at any time by providing notice in writing; 2) if I revoke or cancel this authorization, it is not effective for the use or for the disclosure of information that has already occurred; 3) the right to inspect or copy the health information to be used or disclosed; 4) the right to receive a copy of this authorization.

I have had the opportunity to review this authorization and understand its contents. By signing this authorization, I am confirming it accurately reflects my wishes. This authorization will remain in effect for 180 days, unless I revoke it in writing prior to the 180 day term.

_____ _____ _____

Parent/Guardian Printed Name, Signature, Relationship to Youth | Witness | Date

I hereby **revoke** this authorization effective as of this date _____.

_____ _____ _____

Parent/Guardian Printed Name, Signature, Relationship to Youth | Witness | Date

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Federal confidentiality rules (42 CFR Part 2) prohibit you from making any further disclosure/copies of information unless further disclosure is authorized by written consent of the person it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of 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. This information is also protected by Ohio Revised Code 5122.