FAMILY & CHILDREN FIRST COUNCIL OF COSHOCTON COUNTY
CONSENT OF RELEASE OF INFORMATION

_____ _____
Person's Full Name Date of Birth

_____ _____
Social Security Number Individual Case Number

Creative Options members have my permission to use and/or disclose protected health information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person. Creative Options includes the following agencies.

Coshocton County Department of Job & Family Services
Coshocton County Health Department
Coshocton County Board of DD
Mental Health & Recovery Services Board
Department of Youth Services
Thompkin's Child & Adolescent Services
Coshocton Behavioral Health Choices
Help Me Grow
First Step Family Violence Intervention Services
Family PACT/Fatherhood Initiative
Coshocton Alternative School
Buckeye Community Health Plan
Molina Health Care of Ohio
United Health Care
Six County, Inc.
Coshocton City Health Department
Coshocton City Schools
Ridgewood Schools
Riverview Schools
The Mentoring Center of Coshocton County
Head Start
Coshocton County Juvenile Court
Coshocton County Family & Children First Council
Coshocton Opportunity School
Nurturing Families of Coshocton
CareSource
Paramount Advantage
Other: _____

I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual: (Circle Yes, No or N/A and initial.)

CIRCLE ONE			**INITIAL**	
Yes	No	N/A	_____	Identifying Information: Name, birth date, sex, race, address, telephone number, social security number
Yes	No	N/A	_____	Case Information: The above Identifying Information, plus medical (except for HIV, AIDS, mental health treatment records and drug and alcohol treatment records) and social history, treatment/ service history, Individualized Education Plans (IEP's), Individualized Family Service Plans (IFSP's), 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	N/A	_____	HIV and AIDS related diagnosis and treatment:
Yes	No	N/A	_____	Substance Abuse Information: Substance abuse diagnosis, treatment plan, diagnostic intake/assessment, treatment progress, attendance, and drug test results for the past: _____ (specify length of time or number of treatment episodes).
Yes	No	N/A	_____	Mental Health Information: Mental Health diagnosis, treatment plan, diagnostic intake/assessment, medications, treatment progress, psychological/Psychiatric evaluation, attendance, test results.
Yes	No	N/A	_____	Financial Information: Public assistance eligibility and payment information provide for establishing eligibility but not limited to pay stubs, W2's and tax returns, and other financial information.

I understand that the Consent for Release of Information expires **180 days** from the date it is signed or one month after the time I am no longer served by the Family & Children First Council of Coshocton County (whichever comes first unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time in writing, along with the date and my signature. 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 records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. However, I understand that information being disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Family & Children First Council of Coshocton County.

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

This consent expires on the _____ day of _____, 20 _____.

_____	_____	_____
Signature of Person	Printed Name	Date
_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date
_____	_____	_____
Witness/Agency Representative	Printed Name	Date

Violation of 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:

THIS INFORMATION IS PROTECTED BY FEDERAL AND STATE PROVACY LAWS AND REGULATIONS. ANY FURTHER RELEASE OF THIS INFORMATION IS STRICTLY PROHIBITED UNLESS FURTHER DISCLOSURE IS EXPRESSLY AUTHORIZED BY THE INDIVIDUAL; DYS IN CASE OF YOUTH RECORDS; OR APPICABLE EXCEPTIONS IN FEDERAL AND/OR STATE LAW.

1. If the records released include information of any diagnosis or treatment of mental illness, 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 (42 CFR Part 2, the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191 ("HIPAA"), 45 C.F.R. Pts. 160 & 164) 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 on an HIV- related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law (O.R.C. 3701.24.3). 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 in 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.

I hereby revoke this Authorization for Release of Information

_____	_____
Signature	Date