

**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 MR/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 Intervention Services  
 Family PACT

Six County, Inc.  
 Coshocton City Health Department  
 Coshocton City Schools  
 Ridgewood Schools  
 Riverview Schools  
 Big Brother/ Big Sisters  
 Head Start  
 Coshocton County Juvenile Court  
 Coshocton County Family & Children First Council

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.)

<b>CIRCLE ONE</b>			<b>INITIAL</b>
Yes	No	N/A	_____
Yes	No	N/A	_____

**Identifying Information:**

Name, birth date, sex, race, address, telephone number, social security number

**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	_____
Yes	No	N/A	_____
Yes	No	N/A	_____
Yes	No	N/A	_____

**HIV and AIDS related diagnosis and treatment:**

**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).

**Mental Health Information:**

Mental Health diagnosis, treatment plan, diagnostic intake/assessment, medications, treatment progress, psychological/Psychiatric evaluation, attendance, test results.

**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-disclosure 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 PRIVACY 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 APPLICABLE 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 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.

I hereby revoke this Authorization for Release of Information

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date