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

| Person's Full Name  | Date of Birth  Individual Case Number   |  |
|---|---|--|
| Social Security Number  |   |  |
|   | r disclose protected health information regarding service delivery planning ervices for the above named person. Creative Options includes the   |  |
| Allwell Behavioral Health Services Coshocton Behavioral Health Choices Coshocton County Department of Job & Family Services Coshocton County Board of DD Coshocton County Family & Children First Council Coshocton County Head Start Coshocton County Health Department Coshocton City Health Department Coshocton County Juvenile Court Coshocton County Schools Coshocton Alternative School Coshocton City Schools Coshocton Opportunity School Ridgewood Schools Riverview Schools Department of Youth Services First Step Family Violence Intervention Services | Family PACT/Fatherhood Initiative Nurturing Families of Coshocton Medicaid Medicaid Managed Care Plans CareSource Paramount Advantage Buckeye Community Health Plan Molina Health Care of Ohio United Health Care Mental Health & Recovery Services Board Other: Other: Other: Other:   |  |
| individual.  Information regarding the following shall not be released  |   |  |
| CIRCLE ONE INITIAL  |   |  |
| nu  M an  So  In  In  Tr  V   | nation: lentifying Information( Name, birth date, sex, race, address, telephone limber, social security number ) ledical Information (except for HIV, AIDS, mental health treatment records and drug and alcohol treatment records) locial history, treatment/ service history ldividualized Education Plans (IEP's), ldividualized Family Service Plans (IFSP's) ransition plans, locational assessments, rades and attendance |  |

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).

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| Yes | No | N/A | <del></del> | 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, inde/assessment, medications, treatment progress, psychological/Psychiatric evaluation, attendance, test results                                    |
| Yes | No | N/A |             | <u>Financial Information:</u> 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.                       |

• By signing this form, you are consenting to allow personal health information to be entered into an Electronic Protected Health Information (EPHI) medical file, FidelityEHR. FidelityEHR follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, FidelityEHR protects against all unauthorized disclosures and manages compliance for all employees, contractors and vendors. Ohio Family and Children First Council (OFCFC) houses the Fidelity HER system for the Coshocton County Children and Families First Council. Your personal information will not be collected by OFCFC. Only demographic and non-personal identifying information will be collected by OFCFC for data analysis.

I understand that the Consent for Release of Information expires 365 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.

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

| Signature of Person  | Printed Name  | Date   |
|--|---|--|
| Signature of Parent/Guardian   | Printed Name  | Date   |
| Witness/Agency Representative  | Printed Name  | Date   |
| I understand that my signing or refusing t                                   | o sign this consent will not affect public ber  | nefits or services for which I am eligible.  |
| This consent expires on the  | day of  | , 20   |
| Violation of Federal law and regulation district where the violation occurs. | ns is a crime. Suspected violations may be  | reported to the United States Attorney in the  |
| TO ALL AGENCIES RECEIVING IN   | FORMATION DISCLOSED AS A RESU   | JLT OF THIS SIGNED CONSENT:  |
| FURTHER RELEASE OF THIS INFO   | E INDIVIDUAL; DYS IN CASE OF YOU  | ED UNLESS FURTHER DISCLOSURE IS  |
| If the records released include inform following statement applies.          | nation of any diagnosis or treatment of menta   | al illness, drug or alcohol abuse, the   |
| Information disclosed pursuant to this cor Law.                              | nsent has been disclosed to you from records  | s whose confidentiality is protected by Federal  |
| C.F.R. Pts. 160 & 164) prohibit you from                                     | making any further disclosure of it without ed by such regulations. A general authorization | ity Act of 1996 P.L. 104-191 ("HIPAA"), 45 the specific written consent of the person to ion for the release of medical or other |
| 2. If the records released include inform                                    | nation on an HIV- related diagnosis or test re  | esults, the following statement applies:   |
|  | formation without the specific, written and i   | disclosure by state law (O.R.C. 3701.24.3). You informed release of the individual to whom it                                    |
| A general authorization for the release of results or diagnoses.             | medical or other information is NOT suffici   | ient for the purpose of the release of HIV test  |
|  | further disclosure is expressly permitted by  | and/or state confidentiality rules. Any further y the person to whom it pertains, DYS in the                                     |
| I hereby revoke this Autho   | orization for Release of Informa  | tion   |
| Signature  |   |  |