Family&Children FIRST COUNCIL

Addendum B

Informed Consent for Release & Exchange of Information

County: _____Defiance _____Fulton _____Henry _____Williams

I herby give permission to release and exchange information regarding those individuals listed below for whom I have legal authority to act. The purposes of this release and exchange of information are for the following functions of Family & Children First Council service coordination:

1. Review by an interagency group, Family Coordination Team. The Family Coordination Team reviews referrals for assignment to appropriate level of care, allocates resources and monitors case progress.
2. Knowledge of your case for implementation of your service coordination plan by your Child & Family Team members.

Printed Name	Date of Birth

I hereby give permission to release or exchange information with the following agencies for the purposes outlined above. I understand designated representatives from some or all of these agencies may attend the Family Coordination Team meetings in the county selected above and my Child & Family Team meetings and by their participation they will have access to private health information regarding the individuals listed above. I understand these agency representatives are required to sign a confidentiality of protected health information agreement. ***Agencies listed in bold are mandatory for Family Coordination Team in the county selected above.**

	Family and Children First Council			**City/County Schools**
	Four County Family Center			**Northwest Ohio Educational Service Center**
	County Board of Developmental Disabilities			**Ohio Department of Youth Services**
	County Health Department			Independence Education Center
	County Help Me Grow			Referring Agency:
	County Job & Family Services			
	County Juvenile Probation			
	County Juvenile Court/CASA Representatives			

The following information may be released and exchanged. Please initial each line below.

_____ All case information, including but not limited to identifying information plus privileged health and medical information, social history, treatment/service history, psychological evaluations, IEP's, transition plans, vocational assessments, grades and attendance, financial and parenting information, performance/attendance history and other personal information held by any of the above authorized **agencies providers regarding those individuals** listed above.

_____ Substance abuse diagnosis and treatment.

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. Only the minimum amount of information needed to achieve the stated purposes may be disclosed. 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 Family Coordination Team in the county selected above and my Child & Family Team 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). See note below.

I understand I have 1) the right to revoke or restrict the authorization in writing at anytime and revocation will be effective except to the extent that certain actions reliant on my authorization have already been taken by the Family Coordination Team in the county selected above and/or my Child & Family Team, 2) the right to inspect or copy the health information to be used or disclosed, 3) the right to receive a copy of this authorization.

I have been offered Parent Advocacy Services, which is a mandatory offer for service coordination services. My choice is to □ accept or □ decline.
_____ Please initial.

I have had the opportunity to review this informed consent form and understand its contents. By signing this informed consent form, 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 Child	Witness	Date

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

Parent/Guardian Printed Name, Signature, Relationship to Child	Witness	Date

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without the **specific and informed release of the individual to whom it pertains, their authorized representative** or as otherwise permitted by law. 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.