HANCOCK COUNTY FAMILY FIRST COUNCIL
AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Youth Name: _____ Date of Birth _____

I give my permission for the following agencies/organizations through their designated representatives to exchange information regarding case history and treatment goals of the above-named youth in order to develop an Individualized Family Service Coordination Plan.

ADAMHS Board	HC Sheriff's Department
Aetna Better Health of Ohio	Hancock Public Health
Family Resource Center	Harbor
Electronic Health Record	Hope House
Findlay City Schools	Medicaid Provider _____
Findlay Police Department	NAMI
Habitat for Humanity	Ohio Dept. of Youth Services
HC Board of Developmental Disabilities	Open Arms
HC Educational Service Center	Opportunities for Ohioans with Disabilities
HC Family and Children First Council	Parent Advocacy Connection
HC Job & Family Services/Children's Protective Services	Physician _____
HC School _____	Other _____
HC Juvenile Court	Other _____

I UNDERSTAND THE INFORMATION ABOUT ME AND MY CHILD, WHEN UNDER SUBPOENA, WILL BE REQUIRED TO BE RELEASED WITH OR WITHOUT MY SIGNED CONSENT.

PURPOSE OF NEED FOR DISCLOSURE: This person is voluntarily participating in a comprehensive service program. Representatives of the above agencies/organizations may be involved in formulating and carrying out the Individualized Family Service Coordination Plan.
SPECIFIC INFORMATION TO BE DISCLOSED: Treatment plan, treatment goals, history, test results (physical, psychiatric, psychological), medications, clinical impressions, obstacles to treatment, comprehensive reunification plan, school/education records, and _____.

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ELECTRONIC HEALTH INFORMATION FILES: I also consent to allow the entry of the above-named youth's personal health information to be entered into a protected Statewide database (OASCIS) and a cloud-based Electronic Protected (EPHI) file. The electronic health record data system follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, the electronic health record data system protects against all unauthorized disclosures and manages compliance for all employees, contractors, and vendors.

I hereby release the Hancock County Family and Children First Council from all legal responsibility or liability that may arise from this authorization.

I have read and fully understand the content of this form. The authorization may be revoked at any time, except to the extent that action has been taken in reliance thereon, by the notification of the Hancock County Family and Children First Council of my intention to do so. This authorization (unless expressly revoked earlier) expires itself upon termination of the case.

_____ / _____ _____
Signature of client/parent/authorized person **`Relationship** **Date**

_____ / _____ _____
Signature of client/parent/authorized person **Relationship** **Date**

_____ _____
***Witness** **Date**

This consent revoked by: _____ **On** _____

Revised 6/27/2022