Delaware County Family & Children First Council
RELEASE OF INFORMATION

CHILD NAME____D.O.B.________________________

I give my permission for the following individuals and/or organizations through their designated representatives to exchange information regarding case history and treatment goals of the above named child in order to develop a Comprehensive Service Plan:

Delaware County Family & Children First Council
Delaware County Job & Family Services/Children's Services
Delaware-Morrow Mental Health & Recovery Services Board and Provider Agencies
Delaware County Board of Developmental Disabilities
Delaware County Juvenile Court
Delaware City Schools
School (District) ___________________________
School Liaison_____________________________
Physician_________________________________

ESC of Central Ohio
Delaware General Health District
Ohio Department of Youth Services
Mental Health/Treatment Provider_____________________
Medicaid Provider ________________________________
Other (Specify) __________________________________
____

The above individuals/organizations may be invited to Service Coordination after discussion and parental agreement.
All may be involved if services are requested that require funding.

PURPOSE OF NEED FOR DISCLOSURE: This person is voluntarily participating in a comprehensive service program. All of the above persons and/or agencies are involved in formulating and carrying out the treatment plan.

I understand the following:
1. The purpose of this information sharing is to improve the communication about services to me and my family.
2. Each of the member agencies have agreed: A. To share this information only with other member agencies. B. Not to share information with non-member agencies without consent otherwise required or authorized by law.
3. Any and all right to confidentiality which I may have under state or federal law will continue, except for information covered by this form.
4. I may revoke this Authorization at any time except for information that has been previously exchanged.
5. This Authorization shall not restrict information sharing otherwise authorized by law.

SPECIFIC INFORMATION TO BE DISCLOSED: Treatment plan, treatment goals, progress towards goals, history, test results (physical, psychiatric, psychological), medications, clinical impressions, obstacles to treatment, Comprehensive Reunification Plan, school/educational records, and:
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Delaware County Inter-agency Youth Council and Family and Children First Council shall follow the privacy regulations of the Health Insurance Portability and Accountability Act ("HIPAA") for use of and protection of the data. All information shall be kept confidential.

The confidentiality of client records is protected by federal and state laws and regulations (42 CFR Part 2). Generally, the program will not convey to a person outside the program that a client attends or receives services from the program or disclose any information identifying a client unless the client consents in writing, the disclosure is allowed by court order, the disclosure is made to medical personnel in a medical emergency or the disclosure is made to qualified personnel for research, audit or program evaluation.

Federal laws and regulations do not protect any information about a crime committed by a client, either at the program or against any person who worksfor the program or about any threat to commit such crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities. Re-release of information requires written informed consent. Disclosures of protected health information to non-covered entities will be subject to the minimum necessary guidelines of CFR 42 Parts 160 and 164 and/or the Ohio Revised Code. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information to whom it pertains or as otherwise permitted by 42 C.F.R. 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

I understand that this Release of Information does not expire unless I revoke the consent. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing. I understand that my signing or refusing to sign this consent will not affect public benefits or services for which I am eligible. **(MUST CHOOSE ONE OF THE FOLLOWING)**

____ I do not request any restrictions on the above releases.

____ I place these restrictions on the above releases: ____

______________________________________ /_____________________ ______________
Signature of client/parent/authorized person Relationship Date

______________________________________ / _____________________ ______________
Signature of client/parent/authorized person Relationship Date

____ ______________
Witness Date