Ashtabula County Family & Children First Council
3914 C Court, Ashtabula, Ohio 44004
phone: 440-998-8178 / fax: 440-992-6828

ASHTABULA COUNTY FAMILY & CHILDREN FIRST COUNCIL RELEASE OF INFORMATION

_____ _____
YOUTH'S FULL NAME DATE OF BIRTH

_____ My initials here signify permission for the creation of and entry of information into an Electronic Protected Health Information (EPHI) medical file, Fidelity EHR, regarding the youth listed above <u>for whom I have the legal authority to act</u> for the purposes of Service Coordination. Fidelity EHR 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 of EPHI. Further, Fidelity EHR protects against all unauthorized disclosures and manages compliance for all employees, contactors and vendors. Ohio Family & Children First Council (OFCFC) houses the Fidelity EHR system for the Ashtabula County Family & Children First Council. Your personal information will not be collected by OFCFC. Only demographic data and non-personal identifying information will be collected by OFCFC for data analysis.

_____ My initials here signify permission granted to the agencies, organizations, and natural supports listed below, through their designated representatives, to exchange information with the Ashtabula County Family & Children First Council for the purposes of Service Coordination regarding the youth listed above <u>for whom I have the legal authority to act</u>.

_____ My initials here indicate the understanding that the sole purpose for this exchange of information is to develop a cross system service plan for the youth listed above <u>for whom I have the legal authority to act</u> unless otherwise specified here: _____

Ashtabula County Board of Developmental Disabilities
Ashtabula County Children Services Board
Ashtabula County Department of Job & Family Services
Ashtabula County Educational Service Center
Ashtabula County Family & Children First Council
Ashtabula County Community Action Agency
Ashtabula County Health Department
Ashtabula County Juvenile Court
Ashtabula County Mental Health & Recovery Services Board
Community Counseling Center
Lake Area Recovery Center
Signature Health
Family Pride of Northeast Ohio, Inc.

Youth's Current School:

_____

Youth's Home District (+ District of Responsibility if different):

_____

OTHER (list any other medical, service or activity providers we might need to communicate with here):

_____

_____

NATURAL SUPPORTS

	Name	Relationship to Youth	Date Added	Guardian Initials
1.				
2.				
3.				
4.				
5.				
6.				

_____ **My initials here signify my authorization for the release of the specific information for which I have initialed below, and understand that <u>this information will only be accessed if it is necessary to secure or coordinate needed services</u> identified on behalf of this youth/family by the agencies / organizations listed above.**

<u>INITIAL</u>

_____ Identifying information: name, birth date, sex, race, address and telephone number

_____ General Medical: medical records (except for HIV, AIDS or drug/alcohol treatment records) disability, type of services received and name of agency providing services to me/the individual named above.

_____ Social History: social history, treatment/service history, psychological evaluations and other personal information regarding me/the above individual.

_____ School information: grades, attendance records, Individual Education Plan (IEP), Individualized Family Service Plan, Individual Service Plan, Multi-Factored Evaluation, Children's/Ohio Determination Instrument (COEDI/OEDI), transition plans, vocational assessments regarding me/the above individual.

_____ HIV and AIDS related diagnosis and treatment

_____ Current substance abuse treatment, recommendations and involvement

_____ Financial information necessary to establish eligibility for benefits or other forms of assistance

_____ Mental health treatment information regarding the individual named above or me.

_____ Other (please specify): _____

I understand that all alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that some information, not connected to any personally identifying information, will be collected for reporting purposes as required by the funding sources utilized to run this program. This information is used to demonstrate general information about services provided and needs in the community, and I can request to view this information by contacting Ashtabula County Family & Children First Council (3914 C Court, Ashtabula, OH 44004).

I understand this document expires on **____/____/____**, 180 days from the date signed, unless otherwise indicated to me. I also understand that I may cancel this Release of Information at any time by requesting this in writing, including my signature and date, and delivering it to: Ashtabula County Family & Children First Council (3914 C Court, Ashtabula, OH 44004). Cancellation is effective from that day forward but does not apply to information already shared.

I understand that signing or refusing to sign this Release of Information will not affect public benefits/services for which I am eligible, unless otherwise required by the regulations of the agency responsible for administration of the same.

I understand that the information disclosed pursuant to this authorization may be the subject of re-disclosure to the entities covered by this Release of Information and to no one else without permission.

My signature below confirms that I have the legal authority to act on behalf of this youth.

Print Full Name & Relationship to Youth	Signature	Date

Printed Full Name of Youth	Signature (**required if current/past recipient of substance abuse treatment**)	Date

Printed Full Name of Witness	Signature	Date

TO ALL AGENCIES SENDING/RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. **If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT statement applies**: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit 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.
2. **If the records released include information of an HIV-related diagnosis or test results, the following statement applies**: This information has been disclosed from confidential records protected from disclosure by state law. No further disclosure of this information is permitted 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 diagnosis.
3. The information has been disclosed from records covered by this document and protected by federal and/or state confidentiality and privacy rules. Any further release is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.

Violation of Federal laws and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

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