AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose of Form and Uses of Information: This authorization allows the noted systems and providers to share information about the child named below. Information will be used to: (1) develop the child's treatment planning (including wraparound services); (2) coordinate and pay for services; and (3) evaluate the quality and cost-effectiveness of services.

Child's Name	Soc. Sec. No. - -	Date of Birth (mm/dd/yyyy) or age:
Address:		Tel. No. ( )
City		State/Zip

Authorized Systems and Providers: The listed public systems and private providers work together as Cuyahoga County Family and Children First Council.

Please state **specific** the purpose of this release:

_____

_____

_____

Check **(V)** the **EXC** box to consent to 2-way sharing OR

- Write **(DIS)** in the EXC box if **only** disclosing information or **(REC)** if **only** receiving information.
- Identify the child's **school/district** and any other systems or private providers whose information might help us provide better services for the child.

EXC		EXC	
	Cuyahoga County Family and Children First Council		Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County
	Cuyahoga County Juvenile Court		Behavioral Health Provider
	Cuyahoga County Division of Children and Family Services		Behavioral Health Provider
	Cuyahoga County Board of Developmental Disabilities		Starting Point
	Cuyahoga County Department of Job and Family Services		Bright Beginnings
	_____School/School District _____		ESCNEO
	Department of Youth Services		Other

Information to Be Exchanged*:* **I authorize the release of the specific information which I have initialed below** *(Initial all that apply)* - includes records from the previous 12 months, unless otherwise limited

_____ **Identifying Information*: (Name, birth date, sex, race, address, telephone number)***

_____ **Social Security Number, UCI number if any *(for Medicaid purposes)***

_____ **Education Records, per 34 CFR Part 99**

_____ **Mental Health Records: Personal/social history, Psychological/Psychiatric Assessments, Evaluations, Treatment & Service History**

_____ **Juvenile Court records**

_____ **Medical Records – records of health care providers related to general health**
(Except HIV, AIDs and drug and alcohol treatment)

_____ **AIDS/HIV diagnoses, tests and other communicable diseases, as permitted by state and federal law**

_____ **Alcohol and/or Drug Abuse Treatment records as permitted by state and federal law *(42 CFR Part 2)***

_____ **Financial Information necessary to establish eligibility for public assistance.**
(This may include pay stubs, W-2 and tax return information, and other general financial information. Confirmation of Public Assistance eligibility (categories and types) which I may be currently receiving)

ALL HIGHLIGHTED AREAS ON RELEASE MUST BE COMPLETED

_____ **The following other information:** _____

AMOUNT OF INFORMATION TO BE DISCLOSED:

☐ From the past three months Other Amount:_____

☐ From the most recent admission or episode

AUTHORIZATION

- I authorize the checked systems and providers to exchange/disclose/receive the initialed information about the child identified above for the reasons noted.
- I understand that signing or refusing to sign this consent will not affect public benefits or services for which the child or I are eligible, unless otherwise required by law.
- **Revocation:** This Release is subject to revocation at any time. I may cancel this release by submitting a signed and dated written request to: _____. **Revoking this Release will become effective the date of the cancellation and will apply to that day forward and not to information already shared.**
- **Expiration:** I understand that this authorization will expire _____ days after the date the form is signed by the parent/guardian, **unless I limit the time frame or cancel this authorization in writing**, or I choose to limit the time frame to the following date: _____. This request was initiated by _____, a Family and Children First Council member.
- I understand that canceling this authorization does not apply to any information already shared in reliance on this authorization.

_____	_____	_____
Printed Name: Parent/Legal Guardian	**Signature**	**Date**
_____	_____	_____
Printed Name: Child/Youth (if 12 years of age or over)	**Signature**	**Date**
_____	_____	_____
Printed Name: Witness/Agency/System	**Signature**	**Date**

* Information used or disclosed may be subject to re-disclosure and may no longer be protected under federal law.

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED UNDER THIS AUTHORIZATION

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

PROHIBITION
ON REDISCLOSURE OF INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT.

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.

2. **HIV RECORDS:** If the records released include information of an HIV-related diagnosis or test results, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information 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 diagnoses.
3. **ALL RECORDS:** The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release is prohibited unless expressly permitted by the person, to whom it pertains, by Juvenile Court/DYS in the case of youth records, or under applicable federal and/or state law.

CANCELLATION

I, the parent/legal guardian named above, wish to cancel this authorization effective as of this date: _____.

Signature of Parent/ Guardian: _____ Witness Initials: _____

ALL HIGHLIGHTED AREAS ON RELEASE MUST BE COMPLETED