Guernsey County Family & Children First Council

Creative Options Committee

Consent for Release of Information

Creative Options Case Number _____ Date of Referral _____

Release of Information Expires on: _____

Name of child	Date of Birth	Social Security Number	Age	Grade	School DIstrict

Name of Parent/Guardian	Date of Birth	Social Security Number

The following agencies have my/our permission to use and disclose information regarding service delivery planning for the purpose of securing, coordinating and providing services for the individuals named above. This information may include protected health information.

- ☐ Guernsey County Board of DD
- ☐ Guernsey County Children Services Board
- ☐ Guernsey County Job & Family Services
- ☐ Guernsey County Juvenile Court
- ☐ Ohio Department of Youth Services
- ☐ Cambridge-Guernsey County Health Dept.
- ☐ Mental Health and Recovery Services Board
- ☐ CASA
- ☐ Cambridge Counseling
- ☐ People To People, Inc.
- ☐ Allwell Behavioral health Services
- ☐ Ohio Valley Educational Service Center
- ☐ Cambridge City School District
- ☐ East Guernsey Local School District
- ☐ Rolling Hills School District
- ☐ East Muskingum Local School District
- ☐ Help Me Grow
- ☐ CareSource
- ☐ Molina Healthcare
- ☐ Buckeye Community Health
- ☐ United Healthcare
- ☐ Cedar Ridge
- ☐ Paramount Health Care
- ☐ Alcohol and Drug Services of Guernsey County
- ☐ CANS/PHI to Fidelity EHR
- ☐ Creative Options Reporting Board

_____

Creative Options Committee

Consent for Release of Information

I authorize sharing of the following information, if needed, by the receiving agency to secure, coordinate and provide services to the individual/s. (Yes, No, or N/A and initial).

◉Yes ◯No ◯N/A _____ **Identifying Information:** name, birth date, sex, race, address, telephone number, social security number

◉Yes ◯No ◯N/A _____ **Case Information:** the above identifying information, plus medical (except for HIV, AIDS, mental health treatment records and drug and alcohol treatment records) and social history, treatment/service history, individualized education plans (IEP), transition plans, vocational assessments, grades and attendance and other personal information regarding me or the individual named above and all other information regarding disabilities, type of services being received and name of agency providing services to the individuals named above.

◉Yes ◯No ◯N/A _____ **HIV and AIDS related diagnosis and treatment**

◉Yes ◯No ◯N/A _____ **Substance Abuse Information:** substance abuse diagnosis, treatment plans, diagnostic intake / assessment, treatment progress, attendance, drug test results

◉Yes ◯No ◯N/A _____ **Mental Health Information:** diagnosis, treatment plan, diagnostic intake/ assessment, medications, treatment progress, psychological and/or psychiatric evaluation, attendance, test results

◉Yes ◯No ◯N/A _____ **Financial Information:** income, revenue, savings, assets, and public assistance eligibility information including but not limited to pay stubs, W-2 forms, tax returns, records from employers, financial institutions and public assistance agencies

I understand that this Consent for Release of Information expires 180 days from the date it is signed unless otherwise indicated herein by the individual, or a legal guardian. I also understand that I may cancel this consent at any time in writing, including date and signature. The revocation does not include any information which has been shared between the time the consent was given and rescinded.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. However, I understand that information being disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Creative Options.

Creative Options Committee

Consent for Release of Information

I understand that my signing or refusal to sign this consent will not affect public benefits or services for which I am eligible.

This consent expires on the _____ day of _____ Year:

Child Name (Print) Signature Date

_____

_____

_____

_____

_____

_____

Parent/Guardian Name (Print) Signature Date

_____

_____

Witness (Print) Signature Date

_____

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

TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT.

1. This information is protected by federal and/or state rules of confidentiality. Any further disclosure is prohibited without specific, written and informed consent from the individual to whom the information pertains, the Depart ment of Youth Services in the case of youth records, or as permitted by applicable state and/or federal law.

2. If the records released include information on diagnosis or treatment of mental illness, drug or alcohol abuse the following statement applies: this information has been disclosed to you from records whose confidentiality is pro tected by federal law.

Federal regulations (42 C.F.R., Part 2, the Health Insurance and Portability and Accountability Act of 1996 P.L. 104-191 (HIPAA), 45 C.F.R. Parts 160 & 164) prohibit any further disclose of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by said regulations. A general authorization for the release of other information is not sufficient for further release or sharing of this information.