SENECA COUNTY
CLIENT AUTHORIZATION FOR INFORMATION SHARING

I hereby authorize the Member agencies of the Family & Children First Council of Seneca County, named on the reverse side of this Authorization, to exchange, give, receive, share, or redisclose information in their records, from whatever source derived, related to my participation and that of my minor child:

Name of Individual:_____ Date of Birth:_____ Social Security #_____

in the services provided by one or more of these agencies.

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 has agreed:
   a) To share this information only with other member agencies;
   b) Not to share information with non-member agencies without my written consent unless otherwise required or authorized by law; and
   c) Information exchanged due to this authorization will not be used against me or my children for purposes of criminal investigation, prosecution, or sentencing, unless otherwise required by law or judicial order.
3. Any and all rights 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 automatically expire 180 days from the date below unless I revoke it sooner.
6. This Authorization shall not restrict information sharing otherwise authorized by law.

I authorize sharing of the following information (Circle and initial, if yes, and sign below)

Yes _____ Case Information: Identifying information, plus medical and social history, treatment/service history, Psychological evaluations, IEP's, IFSP's, transition plans, vocational assessments, grades and attendance, financial information and other personal information held by any of the member agencies regarding me or my minor children.

Yes _____ HIV and AIDS-related diagnosis and treatment

Yes _____ Substance abuse diagnosis and treatment

Yes _____ Social Security Number

If yes: This Authorization for information sharing has been explained to me. I have read the disclosures below. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

_____ _____
Signature of Client Date Signed

_____ _____
Signature of Parent/Guardian (if applicable) Staff Person Facilitating this Authorization

_____ _____
Relationship of Person Signing to Client If applicable, date of revocation. (Revocation must be submitted in writing)

Authorization for Information Sharing (page 2)

MEMBER AGENCIES: (PLEASE CHECK EACH FOR AUTHORIZATION)

_____ Family & Children First Council Director/Council

_____ United Way/First Call For Help

_____ North Central Ohio ESC

_____ Tiffin City Schools

_____ Fostoria City Schools

_____ Seneca County Board of DD

_____ Seneca County Dept. of Job & Family Services

_____ Seneca County Juvenile Court

_____ Ohio Department of Youth Services

_____ Firelands Counseling and Recovery Services

_____ Lutheran Social Service

_____ Seneca County Help Me Grow

_____ Seneca County Health Department

_____ Great Lakes Community Action Commission

_____ CASA

_____ Mental Health of Recovery Services Board of Seneca, Ottawa, Sandusky & Wyandot Counties

_____ Mercy Hospital/ Mercy OB

_____ Regional/Local Family Advocates

_____ Aetna

_____ Harbor

I am also authorizing the exchange of information with the following specific persons/agencies:

_____ _____

_____ _____

_____ _____

_____ _____
Signature of Client (or Parent/Guardian if applicable) Date Signed

Definition of "Case Information":

If this release authorizes the disclosure of Case Information, consent to such disclosure may include the following types of information, if it is in files of the agency disclosing this information:

a) Identifying information: names, birth dates, sex, race, address, telephone number, social security number, type of services being received and name of agency providing services to me or my minor children. Medical records, including but not limited to results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment services received, summary of treatment plans and treatment needs.
b) Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, and other test results.
c) All records of services provided by the Seneca County Department of Job and Family Services except child abuse investigation reports.
d) Juvenile court and detention records.
e) School records: This information is subject to the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g, and the Ohio Student Records Privacy Act RC 3319.321.

To all Agencies receiving information disclosed pursuant to this consent:

If the records released pursuant to this consent include records of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

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 pertained 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.

If the records released include information of 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 diagnosis.