Fairfield County Family, Adult and Children First Council

MULTI-SYSTEM YOUTH SERVICE COORDINATION CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

CLIENT'S NAME: _____ **DATE OF BIRTH:** _____

I, _____ (relationship to client) _____ , **authorize:**

FAIRFIELD COUNTY FACFC SERVICE COORDINATION AGENCIES

Big Brothers Big Sisters
Fairfield County ADAMH Board
Fairfield County Bd. of Developmental Disabilities
Fairfield County Family, Adult and Children First Council
Fairfield County Help Me Grow Early Intervention
Fairfield County Job and Family Services:
- Protective Services
- Child Support Enforcement
- Community Services

Fairfield County Juvenile Court
Integrated Services Behavioral Health
Lancaster-Fairfield Community Action Agency – Head Start / Social Services
Mid-Ohio Psychological Services
New Horizons Behavioral Health
Ohio Guidestone
School and Education Service Center (specify):
_____
Other agencies / persons (specify):
_____
_____
_____

TO DO THE FOLLOWING:

- Share identifying information across child-serving agencies and systems for the benefit of service coordination and service delivery for the child and family. Identifying information: name, birth date, sex, address, telephone numbers, social security number.
- Share General Medical: Medical records (except for HIV, AIDS) disability, type of services being received and name of agency providing services.
- Share Social History: Treatment/service history, psychological evaluations and other personal information regarding the individual named above.
- Share Educational Information as FERPA Release: grades, attendance records, test scores, disciplinary records, IEP (individual education plan), ETR/MFE (multi-factored evaluation), IFSP (individualized family service plan), Section 504 plan, COEDI (children's Ohio eligibility determination instrument), OEDI (Ohio eligibility determination instrument – adult), transition plans and vocational assessments regarding the individual named above.
- Share Financial Information: public assistance or other financial eligibility and payment information.
- Measure Outcomes.
- **Share Alcohol/Drug Abuse Services:** you may limit the release to the following as desired: **Check** information that you wish to release.

_____ Diagnostic Information
_____ Evaluation/Assessments
_____ Treatment Plan
_____ Ongoing Communication to Facilitate Services
_____ Psychosocial History
_____ Outcome of Treatment
_____ Recommendations
_____ Other:

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

*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 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. Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 and 164. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**I understand and acknowledge that this Authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse, (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome AIDS) test results or diagnoses (ORC3701 24.3).

I understand that knowledge so obtained will be treated in a confidential manner. A photostatic copy of this authorization shall be considered valid. **This consent (unless expressly revoked earlier) expires when the case is terminated.**

By signing this form, you are consenting to allow personal information to be entered into two (2) web-based data portals maintained by the State of Ohio: "OASCIS" by Ohio Dept. of Job and Family Services (ODJFS) and "CANS" by Ohio Dept. of Medicaid (ODM). ODJFS and ODM ensure that all information entered meets federal and state confidentiality and security requirements and takes action to mitigate any reasonable risks and hazards. Further, ODJFS and ODM protect against all unauthorized disclosures and manages compliance for all employees, contractors and vendors.

This form has been fully explained to me and I certify that I understand its contents.

Signature: _____ Date: _____

Parent/Guardian or Person Authorized to Consent

Signature: _____ Date: _____

CHILD Authorization (to release AoD information and/or if 18+ years old)

Witness: _____ Date: _____

If choosing to REVOKE, complete the following section:

Written Revocation: I wish to cancel this Release effective: (give date) _____

Date

_____ _____

Parent/Guardian or Person Authorized to revoke consent Date

_____ _____

Witness Date

_____ / 8/12/22

(Approved as to form) (Date)