Fairfield County Perinatal Cluster Services
Consent for Release of Information

Client Name:_____ Date of Birth: _____Phone:_____

Client Address:_____City_____State_____Zip_____

Client Email Address: _____

I authorize the following agencies and/or organizations the right to exchange information regarding case history, psychological and education assessments, treatment, and progress updates in order to develop comprehensive service coordination goals that meet the needs of this client and/or family. Information released under this authorization may be subject to re-disclosure by the recipient of the information.

The agencies/organizations listed below have my permission to exchange/share information while assisting me with services through the Perinatal Services Council. If there are exclusions, please indicate.

Fairfield County ADAMH Board

Fairfield County Board of Developmental Disabilities

Fairfield County Department of Health

Fairfield County Department of Job and Family Services (specify if there are exclusions)
_____Child Protective Services
_____Child Support Enforcement
_____Community Services

Lancaster-Fairfield Community Action Agency
_____ Early Childhood Programs
_____ Housing Assistance and Supports for Youth
_____ Social Services

Fairfield County Family, Adult and Children First Council

Fairfield County Help Me Grow

Fairfield Medical Center

New Horizons Mental Health Services

Pickerington Area Counseling Office

The Recovery Center

Ohio Guidestone

School (specify)_____

Other Hospital (specify)_____

Other Agency/Organization (specify)_____

Integrated Services Behavioral Health

Mid-Ohio Psychological Services

I understand that I may revoke my consent to release information at any time. This consent form is valid for one year from the date the release is signed or as otherwise stated.

_____/_____
(Client Signature) (Date)

Sign below only if you wish to revoke your consent.
Revocation of consent: I hereby revoke the above consent for release of information.
Upon revocations of consent, further release of specified information shall cease immediately.
_____ / _____
(Client Signature) (Date)

Client Name_____ Referral Date _____

Email_____ Date of Birth _____

Address_____

City_____ Zip Code _____

Phone_____ Texting Permitted? _____

Race_____ Gender_____ Primary Language _____

Referring Person/Agency _____

Possible Services Requested _____

Family Members:

- Mother_____ Address_____
  Home Phone_____ Cell Phone _____
  Employer _____
- Father_____ Address _____
  Home Phone_____ Cell Phone _____
  Employer _____
- Is there a Significant Other (i.e. boyfriend/girlfriend/relative) living in the home? _____
  Name_____ Relationship_____ Phone_____
  May information be shared with them? _____
- Child/Children (Please list all children)

  Son/Daughter Name_____ Age_____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name_____ Age_____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name_____ Age_____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name_____ Age_____ Date of Birth _____
  Currently resides with _____

  Is Mother currently pregnant?_____ Due Date _____
  Is Mother currently receiving OB/GYN Care?_____ Physician _____

Is client and family in a stable living environment? _____

If not, please explain housing needs: _____

Agency Involvement (check all that apply)

_____Child Protective Services: Caseworker _____

_____Court Program: Probation Officer _____

_____Psychiatrist: Agency/Doctor _____

_____Psychological Assessment: Agency _____

_____Therapist: Agency _____

_____Other: Agency_____

Hospitalizations _____

_____

Medications _____

_____

Insurance Information

_____ Private Insurance

_____ Medicaid

Provider _____

Managed Care Provider _____

Financial Information

Annual gross income from Mother _____

Annual gross income from Father _____

Other income (i.e. child support, retirement, social security etc.) _____

_____

_____

Please write a brief summary of client needs and services requested from Fairfield County Perinatal Services Cluster

All referrals should be sent to:
Fairfield County Family, Adult
and Children First Council
831 College Ave., Suite C
Lancaster Ohio 43130
740-652-7284
740-681-5540 (Fax)

Referrals will be presented and reviewed at the monthly Fairfield County Perinatal Services Cluster meetings.