Family Center by the Falls
8402 Chagrin Rd, Suite 14B
Chagrin, OH 44023

AUTHORIZATION & CONSENT FOR RELEASE OF INFORMATION

____
Patient's Full Name   Date of Birth

____
Social Security Number

The following persons/programs/agencies have my permission to coordinate service planning and delivery for the above named person by disclosing specific information for the following specific purpose (s). **Testing, Treatment Planning, and Case Coordination.**

A COPY MAY BE ACCEPTED AS A SUBSTITUTE FOR AN ORIGINAL FORM

Please initial all persons/programs/agencies that may disclose and/or receive information
for the purposes listed above.

Give	Receive	
_____	_____	Family Center by the Falls________________________________
_____	_____	____(Doctor)
_____	_____	____(School)
_____	_____	____(Other)
_____	_____	____(Other)
_____	_____	____(Other)

Place a diagonal line through blank lines above and initial.

I authorize the release of the specific information for which I have circled and initialed below only if it is necessary to secure or coordinate needed services identified in my case plan by the persons/programs/ agencies identified above:

Circle and initial

Yes	No	_______	Identifying information: name, birth date, sex, race, address and telephone number.
Yes	No	_______	Social Security Number
Yes	No	_______	General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) disability, type of services being received and name of agency providing services to me or the individual named above.
Yes	No	_______	Social History: social history, treatment/service history and other personal information regarding the individual named above or me.
Yes	No	_______	Mental Health: Diagnostic Assessment, treatment plans, transfer/discharge summaries, psychological assessments, psychiatric evaluations, treatment summaries, lab results and medication histories.
Yes	No	_______	School Information: grades, attendance records, Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), Individualized Service Plan (ISP), Multi-Factored Evaluation (MFE), (Children's) Ohio Eligibility Determination Instrument (COEDI/OEDI), discipline reports, transition plans and vocational assessments regarding me or the individual named above.

RELEASE OF INFORMATION MUST BE 2-SIDED

Yes No _______ HIV and AIDS related diagnosis and treatment.

Yes No _______ Current substance abuse treatment, recommendations and involvement specifically, **if circled yes then give dates and place of service**____

Yes No _______ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.

Yes No ______ Juvenile Court: Disposition Investigation Report, Face Sheet, Complaints, Magistrate's and Judge's Orders, Court Appearances and Dispositions, Hoge and Andrews Youth Level of Service/Case Management Inventory, Facility Reports, Detention Home Reports, MAYSI, police reports.

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand this Release expires 180 days from the date it is signed unless otherwise indicated by me. I also understand that I may cancel this Release at any time in writing with my signature, and the date it is signed, and delivering it to **Steve Grcevich, MD at Family Center by the Falls**. Canceling it applies to that day forward and not to information already shared.

I understand that signing or refusing to sign this Release may affect public benefits or services for which I am eligible, unless otherwise required by the regulations of the agency.

I understand that the information disclosed pursuant to this authorization may be the subject of re-disclosure by the recipient, for necessary and appropriate Integrated Services Partnership reasons without further protection.

If not previously revoked, this consent expires on the ________day of_____________________, 20_____.

______________________________ ______________________

Client Signature Date

______________________________ ______________________

Parent/Guardian Signature Date

______________________________ ______________________

Witness/Agency Representative Date

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

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 CLIENT 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. 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. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, Juvenile Court/DYS in the case of youth records, or applicable federal and/or state law.