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Tuscarawas County Family & Children First Council

RELEASE OF INFORMATION

I, _____, hereby authorize the agencies and entities, which comprise of the Tuscarawas County Family and Children First Council, service coordination team, review team, Community Care Team, OhioRISE team and/or Multi-System Youth Review Team and are initialed below, to exchange information (from whatever source derived) related to both my own participation and that of my minor child in the services they provide.

I understand that the identified agencies may be contacted (please initial).

	Tuscarawas County Board of Developmental Disabilities		Ohio Guidestone		Other:
	Tuscarawas County Juvenile Court		The Village Network		Other:
	Tuscarawas County Department of Job & Family Services - Human Services		Akron Children's Hospital		Other:
	Tuscarawas County Department of Job and Family Services - Children's Services		Trinity Twin City Health Center		Other:
	Ohio Means Jobs		ALCO Services		Other:
	Springvale Health Centers		Big Brothers Big Sisters		Other:

___If initialed here, I agree to the use of telehealth platforms for videoconferencing between myself, my family, my child, Tuscarawas County Family & Children First Council and the agencies identified above. Please note that third-party applications, such as Zoom, Microsoft Teams, etc., potentially introduce privacy risks.

_____If initialed here, I acknowledge that information may be exchanged with the Ohio Department of Medicaid, Aetna Better Health of Ohio, and Jefferson County Educational Service Center.

The purpose of the sharing of this information is to coordinate, plan, review and evaluate the services and supports provided by Tuscarawas County Family & Children First Council.

I understand the following:

1. The purpose of this information sharing is to facilitate the referral for and coordination of treatment services and to evaluate the effectiveness of these services for my child, family and/or myself.
2. The above listed and initialed agencies and entities have agreed:
    a. To share this information only with others in accordance with this authorization.
    b. Not to share this information with non-affiliated agencies and entities without my written authorization unless otherwise required or authorized by law.
3. Any and all rights to confidentiality that I may have under state of federal law will continue, except for information covered by this form.
4. Ohio Family and Children First Council uses the Ohio Automated Service Coordination Information System (OASCIS), an electronic health record data system to collect and analyze data on children/families served through or Service Coordination.^^
5. The Child and Adolescent Needs & Strengths (CANS) tool is an assessment used by Tuscarawas County Family & Children First Council. The CANS assessment will be entered into the statewide CANS IT database.^^

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6. Any information related to the status of HIV or AIDS confirmation will not be released without a written authorization to share the information specifying to whom and for what intended purpose.
7. I may revoke this authorization at any time except related to information that has been previously exchanged.
8. This release of information shall not restrict the sharing of information otherwise authorized by law.
9. All reports and publications of findings related to the evaluation of services received will not reveal my name or that of my family members, and all information and results will be presented in group format.
10. This information is subject to re-disclosure.

^^Information on my child, family, and/or myself may be accessed and used for the purpose of providing and evaluating services or coordinating care for my child, family, and/or myself by state agencies and agencies from other counties who utilize the same statewide electronic health record/database on a need to know basis. Information may be reported in aggregate form on state and local reports.

_____ _____

Name of the Child Date of Birth

_____ _____

Name of Parent/Guardian Parent/Guardian DOB Name of Parent / Guardian Parent/Guardian DOB

Check one:

□ This Release of Information covers the length of my involvement and the involvement of my child with Tuscarawas County Family and Children First Council, without expiration.

□ I request that this Release of Information be reviewed and re-signed on _____(date) or in ___ months from the original date.

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my child and me:

1. Records of services provided by any of the above-mentioned agencies or entities.
2. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional functioning or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, or other test results.
3. 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 or services received, summary of treatment plans and treatment needs, social history and financial information.
4. Drug and alcohol abuse diagnoses and treatment including, but not limited to, results of evaluations, diagnoses, treatment and services received, treatment plans and treatment needs. (This information will be disclosed ONLY IF INITIALED here to permit such release _____). *
5. Any information regarding HIV and AIDS diagnoses and treatment. (This information will be disclosed ONLY IF INITIALED here to permit such release _____). **
6. Treatment summaries and recommendations from above-mentioned agencies or entities.

*Information disclosed pursuant to this authorization has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit further disclosure of alcohol or drug related diagnosis or treatment information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Information disclosed pursuant to 45 CFR 10 and/or treatment without specific written consent to the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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AGREEMENT:

This Release of Information has been explained to me. 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 Child	Effective Date
_____	_____
Signature of Parent/Guardian	Effective Date
_____	_____
Witness	Effective Date

□ I revoke this release of information effective _____for ▬ all listed entities ▬ for entities listed below.

REFUSAL:

Initial and sign below:

I refuse to allow my case information to be exchanged. I understand that my signing or refusing to sign this authorization will not affect public benefits or services to which I am otherwise entitled.

_____	_____
Signature of Child	Effective Date
_____	_____
Signature of Parent/ Guardian	Effective Date
_____	_____
Witness	Effective Date