



RELEASE OF INFORMATION

I, _____, hereby authorize the agencies and entities, which comprise the Clermont County Family and Children First Cluster and are listed below, to exchange information (from whatever source derived) related to both my own participation and that of my minor children in the services they provide.

| | | |
|--|---|--|
| Child Focus, Inc | Clermont County Department of Job and Family Services | Clermont County Mental Health and Recovery Board |
| Clermont County Children's Protective Services | Clermont County Juvenile Court | Families Connected of Clermont County |
| Clermont Recovery Center | Other: | Other: |
| Other: | Other: | Other: |

I also consent to the release and exchange of confidential information to the State Intersystem Collaborative for Youth in the event that the Clermont County Family and Children First Cluster is unable to develop a comprehensive treatment plan for my child.

I understand the following:

1. The purpose of this information sharing is to facilitate the referral for and coordination of treatment services for my child and family.
2. The above listed 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; and
3. Any and all rights to confidentiality that 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 related to information that has been previously exchanged.
5. This Authorization shall automatically expire 6 months from the effective date below unless revoked sooner.
6. This Authorization shall not restrict the sharing of information otherwise authorized by law.

Name of Parent/Guardian

Name of Child

Date of Birth

Name of Child

Date of Birth

Name of Child

Date of Birth

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my children 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 _____). *

*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.

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 |

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 |