RELEASE OF INFORMATION

I, ___________________________, hereby authorize the agencies and entities, which comprise the Clermont County Family and Children First Cluster and/or wraparound team and are initialed below, to exchange information (from whatever source derived) related to both my own participation and that of my minor child(ren) in the services they provide.

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

	Clermont Recovery Center**		Clermont County Department of Job & Family Services		Camelot Community Care
	Child Focus, Inc.		Clermont County Juvenile Court		Pressley Ridge
	Clermont County Mental Health & Recovery Board		Clermont County Children's Protective Services		Families Connected, Inc.
	Clermont County Developmental Disabilities		University of Cincinnati, School of Social Work		Greater Cincinnati Behavioral Health
	Other:		Other:		Other:

****A SEPARATE RELEASE OF INFORMATION MUST BE SIGNED BY THE PARENT/GUARDIAN WHEN COMMUNICATION/INFORMATION IS DESIRED FROM OR WITH CLERMONT RECOVERY CENTER.**

The purpose of the sharing of this information is to coordinate, plan and evaluate the services provided as part of the Individual Family Team Process of Clermont County Wraparound.

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(ren) and family.
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. Any information related to the status HIV or AIDS confirmation will not be released without a written authorization to share the information specifying to whom and for what intended purpose.
5. I may revoke this Authorization at any time except related to information that has been previously exchanged.
6. This Release of Information shall not restrict the sharing of information otherwise authorized by law.
7. 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.

____

Name of Parent/Guardian　　　　　　　　　　Name of Parent / Guardian

____

Name of the Child　　　　　　　　　　Date of Birth

____

Name of the Child　　　　　　　　　　Date of Birth

____

Name of the Child　　　　　　　　　　Date of Birth

Check one:

☐ This Release of Information covers the length of my involvement and the involvement of my child(ren) with Family and Children First, 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(ren) 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 ________________). **

*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 103 privacy rule. No information will be released regarding HIV/AIDS diagnosis 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.

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