LOGAN COUNTY
FAMILY &
CHILDREN FIRST
COUNCIL

# Authorization For
## Release/Request/Exchange of Information

**Youth's Name**

**Youth's Date of Birth**

**Parent/Guardian Name:**

**Name of Person Completing This Form:**

**Relationship to Youth**

I, AUTHORIZE LOGAN COUNTY FAMILY AND CHILDREN FIRST COUNCIL TO REQUEST, USE, AND/OR DISCLOSE PROTECTED HEALTH INFORMATION WITH THE FOLLOWING IN THE MANNER DESCRIBED.

☐ Exchange Information With ☐ Request Information From ☐ Release Information To

**Name of Recipient**

**Address**

**City/State/Zip**

**Phone/Fax**

**Email Address**

THE INFORMATION IDENTIFIED BELOW BY MY **INITIALS** MAY BE TRANSMITTED BY MAIL, FAX, IN PERSON, VERBALLY, OR BY SECURE EMAIL:

_____ All of my Mental Health Information contained in the descriptions selected below.
_____ All of my Substance Use Information contained in the descriptions selected below.
_____ All of my Health Care Information contained in the descriptions selected below.
_____ All OtherInformation contained in the descriptions selected below.

**INTIAL beside the information to be disclosed**

| | | |
|---|---|---|
| _____Assessment Information/Results | _____Progress Notes/Clinical Notes | _____Psychological Testing |
| _____Individualized Service Plan/Review | _____Psychiatric Evaluation | _____ETR/IEP/Behavior Plan |
| _____Treatment Recommendation | _____Laboratory/Drug Screen Results | _____Financial Information |
| _____Transfer/Discharge Summary | _____Medication History | _____Insurance Information |
| _____Treatment Diagnosis | _____Medical Information | _____Other: _____ |
| _____Treatment Progress | _____Hepatitis C Results | _____Other: _____ |

LOGAN COUNTY
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# Authorization For

## Release/Request/Exchange of Information

### YOUTH'S CONTACT INFORMATION

**Youth's Name**

**Youth's Date of Birth**

**Parent/Guardian Name:**

**Name of Person Completing This Form:**

**Relationship to Youth**

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_____ All of my Mental Health Information contained in the descriptions selected below.

_____ All of my Substance Use Information contained in the descriptions selected below.

_____ All of my Health Care Information contained in the descriptions selected below.

_____ All OtherInformation contained in the descriptions selected below.

_____, being the Custodial Parent, the Legal Guardian, or the Legal Representative of the Public Agency having custody of _____, born_____, a minor child, authorizes the member agencies of the COUNCIL FOR LOGAN COUNTY FAMILIES (LOGAN COUNTY FAMILY AND CHILDREN FIRST COUNCIL (FCFC)) authorized below to release, request, and exchange authorized records and information for the above named child to the COUNCIL FOR LOGAN COUNTY FAMILIES. Information provided by the COUNCIL FOR LOGAN COUNTY FAMILIES and its member agencies authorized below will be used through team discussions, assessments, and care coordination for the purpose of developing a Coordinated Plan among involved community agencies.

§I understand that these records will be entered in an electronic health record including enrollment in an electronic billing system.

§ I further understand that these records are protected under Federal and State laws governing Confidentiality of Patient, Student, and Client Records, and cannot be disclosed or re-released without my written consent unless otherwise provided by the regulations.

§ I acknowledge that my child may be eligible and enrolled in OhioRISE and information may be exchanged with the Ohio Department of Medicaid, Aetna Better Health of Ohio, and the National Youth Advocate Program (NYAP) for that purpose.

§ I hereby release the Council for Logan County Families and its member agencies from all legal responsibility or liability that may arise from this authorization.