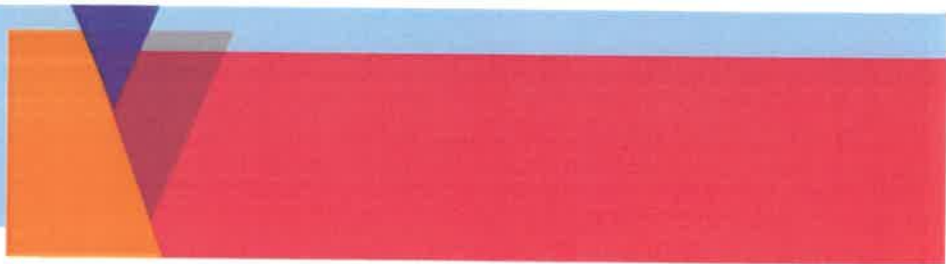

Authorization For

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

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.

_______________________, 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.

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.

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_____ 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: _______________