### CONSENT FOR RELEASE OF INFORMATION

**(Permission for multi-agency comprehensive services & exchange of information)**

|  |  |  |  |
| --- | --- | --- | --- |
| Youth’s Full Name: |  | Date of Birth: |  |

|  |
| --- |
| Ashtabula County Children and Families First Council has my permission to exchange/give/receive/share/re-disclose information and records for the purpose of securing, coordinating, and/or providing services for the above-named person.  |
| Ashtabula County Board of Developmental Disabilities Ashtabula County Children Services BoardAshtabula County Department of Job & Family ServicesAshtabula County Educational Service CenterAshtabula County Mental Health & Recovery Services BoardAshtabula County School DistrictsAshtabula County Family & Children First CouncilAshtabula County Community Action AgencyCadence Care NetworkOhioRISESignature Health |  Catholic Charities of Ashtabula County Ashtabula County and City Health Departments Ashtabula County Juvenile Court Ashtabula County Family Resource CenterCommunity Counseling CenterFamily Pride of Northeast Ohio, Inc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

By signing this form, you are consenting to allow personal information to be entered into two (2) web-based data portals:

1. The Ohio Family and Children First (OFCF) Ohio Automated Service Coordination Information System (OASCIS) customer relations management tool, maintained by the Ohio Dept. of Job and Family Services (ODJFS)
2. The Child and Adolescent Needs and Strengths (CANS) IT portal, maintained by Ohio Dept. of Medicaid (ODM).

ODJFS and ODM follow all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure the confidentiality, integrity, and availability of customer information, and to mitigate any reasonable risks or hazards to customer information. Further, ODJFS and ODM protect against all unauthorized disclosures and manage compliance for all employees, contractors and vendors.

I understand that the Consent for Release of Information expires 180 days from the date it is signed unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to my ACCFFC Family Team Facilitator. The revocation does not include any information which has been shared between the time I gave permission to share information and the time that it was cancelled. In addition, I understand that my signing or refusing to sign this consent form *will not affect public benefits or services for which I am eligible.* ***Furthermore, by signing this form I indicate that I have read and understand the dispute resolution process contained in this document and I have received a copy of this document.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| This consent expires on the |  | day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 20\_\_\_\_\_. |  |
| Signature of Youth: |  | Date: |  |
| Signature of Parent/Guardian: |  | Date: |  |
| Witness/Agency Representative: |  | Date: |  |

TO ALL AGENCIES RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by Federal law.

Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it 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.

1. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is **NOT** sufficient for the purpose of the release of HIV test results or diagnosis.

1. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the further disclosure is expressly permitted by the person to whom it pertains, DYS in the case of youth records, or applicable federal and/or state law.

This form contains privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. Confidentiality Section 2151.421 of the O.R.C. Penalty Section 2152.99 of O.R.C. Thank you for your consideration and confidentiality.

Revision 5-9-2024