CLARK COUNTY CASA/GAL PROGRAM
CONSENT FOR RELEASE OF INFORMATION

Please send this information to:

Agency: _____Clark County Juvenile Court CASA/GAL Program____ **Email:**______casa@clarkohiojuvcourt.us________

Address: __101 E. Columbia Street, Springfield, OH 45502________ **Fax:** ___937-521-3221___________________

CLIENT NAME:___________________________________ **DOB**: _______________________**SSN#:**____________________

***Use a separate Release for each adult or child for whom information is requested.**

I, on behalf of myself, or as the parent, legal guardian or custodian of the above-named individual, do hereby authorize and direct the following organization(s) I have identified with my initials:

____ Aetna
____ CASA/ GAL/ Attorney
____ Catholic Social Services
____ Children's Medical Facility
    _____ Dayton Children's
    _____ Cincinnati Children's
    _____ Nationwide Children's
____ Child Advocacy Center
____ CitiLookout

____ Clark Co. Dept. of Job & Family Svcs.
    _____ Benefits Plus
    _____ Ohio Means Jobs
    _____ Child Support Enforcement (CSE)
    _____ Family & Children Services (FCS)
____ Clark Co. Family & Children First Council (FCFC)
____ Clark Co. FST /MDT Committee & Attendees
____ Clark Co. FCFC IRC Committee & Attendees
____ Clark Co. Juvenile Court
____ Developmental Disabilities of Clark Co.
    _____ Opportunities for Ohioans w Disabilities (OOD)
____ Drug & Alcohol Treatment: __________________
____ Educational Institution (address, fax/email attached)
    _____ Clark Co. Educational Service Center (ESC)
    _____ Springfield City School District
____ Encompass
____ Faith Based Org. ____________________________

_____Family Youth Initiatives FYI
_____ Law Enforcement/Prosecutor: _____________________
_____ Mental Health Services ____________________________
_____ Mental Health Recovery Board of Clark, Greene & Madison Co.
_____ Mercy Reach
_____ Miami Valley Child Development Centers
_____ NYAP (National Youth Advocate Program – CME)
_____ Oesterlen
_____ OhioRISE
_____ Pediatric Associates
_____ Other Pediatrician /Physician: ____________________
_____ Project Woman
_____ Restpoint
_____ Rocking Horse Community Health Center
_____ Salvation Army
_____ Social Security Administration
_____ Springfield Regional Medical Center
_____ Virtual Meetings
_____ WellSpring
_____ Metropolitan Housing
_____ TCN/Consolidated Care
_____ Other: _____________________________________

_____ Other: _____________________________________

_____ Other: _____________________________________
_____ Other: _____________________________________

To release written and verbal communication permitted with my initials:

____ Discharge/Termination Summary
____ Academic plans, Grades, Conduct, Attendance
____ Clinical/ Psychological Assessment(s)
____ Other _________________________________
_____ Physical Assessments/ Medications
_____ Progress Reports/ Case Review Information
_____ Service/ Treatment Case Plan (s)

Information said organization(s) have in their notes or files concerning the above-named individual's involvement with above-initialed organization(s) dated from ___any__________ to __all_______ will be used for the purpose of investigation, treatment, management of the case, data and survey collection, or the processing of payment of claims. **No Mental Health and/or Chemical Dependency information will be re-released except by the custodial entity (parent, guardian, custodian, or custodial agency).**

IMPORTANT INFORMATION- PLEASE READ BEFORE SIGNING

*This Consent for Release of Information will be applicable to information requested and disclosed under both the Health Insurance Portability and Accountability Act (**HIPAA)** and all applicable Federal regulations made under HIPAA, and the Family Education Rights and Privacy Act **(FERPA)** and all applicable Federal regulations made under **FERPA. Furthermore, I hereby authorize and direct that any organization(s) I have identified with my initials may cross release verbal information with any other organization(s) so identified with my initials.** I understand that signing this release is voluntary and it does not need to be signed in order for me to receive treatment. I also understand that there is the potential that any information disclosed as a result of this Consent (to which **HIPAA** may be applicable) may be subject to re-disclosure by anyone who receives the disclosed information and that because of this, such information may no longer be protected under **HIPAA**.*

This consent is subject to revocation in writing at any time except for information already gathered in good faith. If I should revoke my Consent for Release of Information, the revocation does not include any information which has been shared between the time that I gave permission and the time that it was cancelled or any other information to the extent that the relevant agency or entity has taken action in reliance on this Consent for Release of Information.
This authorization (consent for release of information) will remain effective for 90 or 180 days (circle one) unless an earlier date is specified here ___________.

I understand that the agencies receiving this information must hold it as confidential and may not further release it to any other person or agency not identified by my initials, unless specifically authorized to do so. Information will only be shared to the extent necessary to achieve the goals of investigation, treatment, management of the case, or the processing of payment of claims.

Required Notifications Under FERPA

If a parent of a child who signs consent to disclosure of information (this Consent for Release of Information) under ***FERPA*** so requests, the educational agency (______________________________) shall provide him or her with a copy of the records disclosed. If so requested, the educational agency shall also provide a copy of the records disclosed to the student/child who is the subject of the consent to disclosure of information.

Personally identifiable information protected by ***FERPA*** is specifically exempted from ***HIPAA*** privacy standards. ***FERPA*** prevents the disclosure of personally identifiable information without parental I consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to the child's records, and contains complaints and appeal procedures which apply to disputes over records to which ***FERPA*** is applicable.

Chemical Dependency Programs:
When/if you agree to any release of your health information, the following statement is stamped on all released documents per Federal Regulations: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

HIV Release:
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 diagnoses.

Data System Release:
By signing this form, you are consenting to allow personal information to be entered into two (2) web-based data portals maintained by the State of Ohio, specifically Ohio Dept. of Job and Family Services (ODJFS) and Ohio Dept. of Medicaid (ODM). ODJFS and ODM ensure that all information entered meets federal and state confidentiality and security requirements and takes action to mitigate any reasonable risks and hazards. Further, ODJFS and ODM protect against all unauthorized disclosures and manages compliance for all employees, contractors and vendors.

Client Signature: ____
(age 12 and over)

Print Name: Date:

Parent/Guardian Signature: ____

Date:

Print Name:

Witness Signature: ____

Print Name: Date:

This release expires on: Date cannot be more than 180 days from today's date.

I hereby revoke consent: Client signature: ____ Date: ______________

Staff/Witness signature: ____ Date: ______________

Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Revised: 6.14.22

Authorization for the Release and Request of Information

Client Name________________________________	______________ Today's Date
Date of Birth________________________________	
Client Number:______________________________	______________ Expiration Date (6 month or 30 days after discharge)
Social Security Number______________________	

1101 East High St.
Springfield, Ohio 45505
Phone: 937-328-5300
Fax: 937-322-4900

The following programs are authorized to: ☐ disclose, ☐receive, ☒exchange information as noted below.

___________McKinley Hall______________________	__Clark County Juvenile Court CASA/GAL Program_
Program to Make Disclosure	Individual/Organization to Whom Discloser is made
______1101 E. High Street. Spfd., OH 45505 ________	______101 E. Columbia Street, Spfd, OH 45502_______
Address	Address
_____937-328-5300_____________________________	______937-521-1622_____________________________
Phone #	Phone #
_____937-322-4900_____________________________	______937-521-3221____________________________
Fax #	Fax #

Purpose of Disclosure: ☐ To Aid in Treatment ☐to gather Information for ongoing treatment
☐ To Gather Assessment Information
☒ and/or for other purposes: _for investigative purposes________________

Type of Information to be released –Initialed by client: Amount of Information:

______Intake Data	______Psychiatric History/Evaluation	☐ Information covering the most recent Admission
______Developmental/Psychosocial History	______Psychological Evaluation/IQ	
______Alcohol/Drug History	______Treatment and/or Progress Notes	☐Previous three months
______Medical History	______Discharge/Treatment Summaries	
______Academic History File	______All Personally Identifiable Data in File	☒Other ____All records_____ __and documentation______
______Employment History	______Other_________________________	
______Legal Charges/Legal History		

_____________________________________/___/___ _____________________________________/___/___
Signature of Client Date Signature of Staff or Witness Date

Revocation: This authorization is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it. Revocation must be made in writing.

_____________________________________/___/___ _____________________________________/___/___
Signature of Client Date Signature of Staff or Witness Date

This information may be transmitted by mail, fax, or in person.

Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by Federal Confidentiality Laws. The Federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted in written consent of the person to whom it pertains or as otherwise permitted by the 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. Those conditions apply to Drug abuse patient records are also protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 45 C.F.R. parts 160 and 164, (These conditions apply to every page disclosed and copy of this authorization will accompany every disclosure.)

Consent for the Release of Information under 42 C.F.R. PART 2
Confidentiality of Substance Use Disorder Patient Records

I,________________________________ **authorize** Brightview Springfield Addiction Center

(Name of patient) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☒ All my substance use disorder records;

or only the following specific types of records

☐ Attendance ☐ Toxicology Results ☐ Medication(s)/dosing ☐ Assessments ☐ Progress in Treatment

☐ Treatment plan ☐ Lab results ☐ Appointments ☐ Diagnostic information ☐ Insurance info/demographics

☐ Discharge Summary ☐ Substance Use History ☐ Trauma History Summary ☐ Other: ________________________

To: Clark County Juvenile Court CASA/GAL Program

(Name of person or organization to which disclosure is to be made)

Phone: 937-521-1622 Fax: 937-521-3221

For (purpose of disclosure): ☐ Continuity of Care ☐ Coordinating Treatment ☐ Emergency Contact ☐ Payment/benefits administration

☒ Other: Investigative Purposes

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I do not need to sign this form to obtain treatment. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either:

☒ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR**
☐ **upon a specific date, event, or condition as listed here:**____

(Specific date, event or condition)

Patient's Signature:____ Date: ______________________

If the patient is a minor, only the minor can sign this consent.

______________________________ ____________________ ____________________

Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: ____
Print:____ Date: ______________________
Legal Authority: ____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation: ________________________ **Date:** ______________________

NOTICE TO RECIPIENT OF INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

Notice of Federal Requirements Regarding the Confidentiality of Substance Use Disorder Patient Information

The confidentiality of substance use disorder patient records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing; **or**
2. The disclosure is allowed by a court order accompanied by a subpoena; **or**
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; **or**
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program,

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

The releases of information will remain active and valid for one year from the date of signature OR until 90 days after discharge (whichever comes first) OR until a specific date, event, or condition as listed on the form. There are two ways to revoke a release of information: Come in to the BrightView facility where you were scheduled to receive treatment and sign the revocation, or fax in a written statement with your name, signature, date and release(s) you would like to be revoked.

(See 42 U.S.C. §290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.)

MERCYHEALTH

Acct/MRN____________
*Office use only

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Complete all sections entirely. If this authorization is not complete, it may be returned and result in delay in processing.
Photo ID required at the time of request and pick up.

Patient name:	Date of Birth:	Last 4 digits of SS#:	Telephone #:

Mercy Health Hospital or Physician office health information requested from: (Check all that apply)

☐ Anderson ☐ Clermont ☐ Fairfield ☐ The Jewish Hosptial ☐ Mt. Airy ☐ Western Hills
☒ Springfield Regional Medical Center ☐ Mercy Memorial Hospital
☒ Physician/Practice Name: Mercy REACH ☐ Other Healthcare Provider:____________

Dates of service to release: (from): 1/1/15 (to): Present

Specific reports to be disclosed: (Check all that apply)

☒ Abstract of record (Discharge Summary, H&P, Operative Report, Consults, Test results....) ☒ Office Visit
☒ Emergency Department record ☒ History & Physical ☒ Operative report ☒ Discharge Summary
☒ Immunization record ☐ Test results (Lab, Pathology, Radiology, and Cardiac)
☐ Other (Images, Photos):____________
☒ Entire record (standard two years of information, unless otherwise specified):____________

If pick up or mailing records, format selected: ☐ Paper ☒ Electronic (CD) Please fax, email or regular mail

I authorize disclosure of the above listed information to the following individual or organization:
Name: Clark County Juvenile Court CASA/GAL Program, 101 E. Columbia Street, Springfield, OH 45502; casa@clarkohiojuvcourt.us

Information to be disclosed via: (Check one)

☒ Mail to Address: 101 E. Columbia Street, Springfield, OH 45502
Street City State Zip Code

☒ Fax to number: 937-521-3221 (page limitation may apply)

☐ Pick up location/site:____________

☒ Purpose for disclosure: Investigative Purposes
(Continuation of care, Insurance, Legal, Please specify) – For Personal use if not otherwise stated

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes (not included in the Mercy Health Legal health record – separate authorization, only provider/author of notes can disclose)
- This authorization will expire one year from the date of signature below unless otherwise specified.
- I understand and acknowledge that I have the right to cancel/revoke this authorization in writing to the Health Information Manager or other designated representative at the site the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are stated in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer for the site I have requested information from
- **If this authorization is not complete, it may be returned and may result in information not being released until properly completed**
- There may be a charge for copies of records

____________ ____________
Signature of Patient/Patient's Legal Representative Date

Relationship to patient:____________ *(Supporting documentation of authority must be provided)*

Witness (optional):____________

CONSENT TO RELEASE CRIMINAL RECORD INFORMATION

Requesting Department: Clark County Juvenile Court, CASA Program

Person Requesting Information: Abby Easton Program Coordinator

Date: ______/_______/_________ I,_______________________________, _____________
(Today's date) (Print Your Name) (date of birth)

hereby give the Sheriff of Clark County, Ohio, and/or the Springfield City Police Department of Springfield, Ohio, permission to release any records that I may have, to the Clark County Juvenile Court CASA Program. I hereby release the Sheriff of Clark County, Ohio and/or the Springfield City Police Department of Springfield, Ohio from any liability arising from information given, as guaranteed under the Privacy Act.

Optional ************************
*

Race: __________________

Male:{ } Female:{ }

Are you a citizen of the United States?: __________

If yes, how long?: _________
****

____
Signature (In Writing)

____
Address
____

____
Social Security Number

(Sheriff or Police Department Use Only)

Record Information:____

____

____

Person Releasing Information:__________________________Title__________________