CONSENT FOR RELEASE OF INFORMATION

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

Pregnant/Parenting Individual's Full Name:       Date of Birth:

The following agency(s)/individuals have my permission to exchange/give/receive/share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above-named persons.

***(CHECK EACH BOX, INITIAL, and write in the name of the entity/organization authorized to release information)***

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Infant’s Full Name:       Date of Birth:

I further authorize sharing of the following information to any third-party provider of services recommended or referred by Licking County Children Services or the above-named entities.

***(CHECK YES OR NO AND INITIAL EVERY BOX. EVEN THE ONES MARKED NO)***

Yes  No \_\_\_\_\_\_

Yes  No \_\_\_\_\_\_

Yes  No \_\_\_\_\_\_

Identifying Information of pregnant/parenting individual: name, birth date, sex, race, address, and telephone number.

Identifying Information of infant: name, birth date, sex, race, address, and telephone number.

Case Information: The above Identifying Information, plus medical (except for HIV, Aids, and drug and alcohol treatment records), social history, treatment/service history, psychological evaluations, Plans of Safe Care, and other personal information regarding me or the individuals named above (disability, type of service being received and name of agency providing services to me, or the individuals named above).

***Information regarding the following shall not be released unless initialed and marked yes below:***

Yes  No \_\_\_\_\_\_

Yes  No \_\_\_\_\_\_

Yes  No \_\_\_\_\_\_

Yes  No \_\_\_\_\_\_

HIV and Aids-related diagnosis and treatment

Substance abuse diagnosis and treatment

Drug screen/testing results

Financial Information: Public assistance eligibility and payment information provided for establishing eligibility, including but not limited to pay stubs, W2s and tax returns, and other financial information.

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 the individual/representative at the organization obtaining this Release (name of representative). 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.*

This consent expires on the day of 20 .

Signature of pregnant/parenting person: Date:

If pregnant/parenting person is under age 18-Print name of person authorized to consent and relationship to pregnant/parenting person

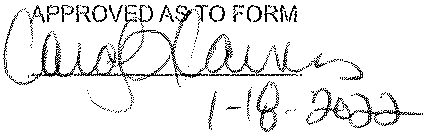
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Signature of person authorized to consent for pregnant/parenting person: --------------

Date: \_\_\_\_\_\_\_\_\_

Print name of person authorized to consent for infant and relationship to infant: Signature of person authorized to sign for infant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:

Witness/Agency Representative 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.***

CONSENT FOR RELEASE OF INFORMATION

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

I . 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 fu1ther 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 medial 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 fi·o1n records protected by federal and/or state confidentiality 1ules. Any fu1ther release of it is prohibited unless the fu1ther disclosure is expressly permitted by the person to whom it pe1tains, 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 21 52.99 of 0.R.C. Thank you for your consideration and confidentiality.

l/l l/2022