Family Support Specialist Program
RELEASE OF INFORMATION

I, _____, authorize the Stark County Family Council to ☐ release ☐ obtain information concerning:

Youth's Name: _____
Date of Birth: _____
Social Security Number: _____

Please check county of residence and corresponding service provider:

West Hub:

☐ Ashland & Wayne County Family and Children First Council **And** ☐ Anazao Community Partners
☐ Holmes & Wayne County Family and Children First Council **And** ☐ Anazao Community Partners
☐ Lorain County Children and Families First Council
☐ Medina County Family First Council
☐ Wayne County Family and Children First Council **And** ☐ Anazao Community Partners

Central Hub:

☐ Portage County Family and Children First Council **And** ☐ Greenleaf Family Center
☐ Stark County Family Council (Serves Portage, Stark and Summit)
☐ Summit County Family and Children First Council

East Hub:

☐ Columbiana County Family and Children First Council **And** ☐ Alta Care Group, Inc (Serves
☐ Mahoning County Family and Children First Council Columbiana, Mahoning and Trumbull)
☐ Trumbull County Family and Children First Council

☐ Any exceptions or exclusions for information released: _____

Please Initial:

_____ I authorize the release of all information required for the coordination of Family Support Specialist Program to/from the following organizations: Stark County Family Council, Stark County Educational Service Center and Ohio Department of Children and Youth.

_____ I understand and acknowledge that this authorization extends to all or any parts of the record designated above, which I may include treatment for mental illness, and/or alcohol/drug abuse/dependency, and/or AIDS/HIV.

_____ I understand that this information will be released only to the participating agency representatives and that any information released to such representatives may not be further disclosed or shared with any person(s)/organizations(s) specifically listed on this form without my written, prior authorization, unless:

- Required to do so by federal and/or state law or regulation.
- Unless an emergency exists.
- Unless permitted by this or other policies of the Stark County Family Council.
- Unless the information has been sufficiently de-identified that the recipient would be unable to link the information to the client.

_____ I understand that these records are protected by state and/or federal confidentiality regulations and cannot be disclosed without my written consent, unless provided for in the 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 to whom it pertains or as otherwise permitted by 42 CFR 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.

_____ I understand the following:

- The purpose of this information sharing is to facilitate the referral for and coordination of treatment services and to evaluate the effectiveness of these services for my child, family, and/or myself.
- Any and all rights to confidentiality that I may have under state or federal law will continue, except for information covered by this form.
- An electronic health record data system through Ohio Family and Children First will be used to collect and analyze data on children/families served through Family Support Specialist Program.
- All reports and publications of findings related to the evaluation of services received will not reveal my name or that of my family members, and all information and results will be presented in group format.

_____ I **do not consent** to the disclosure of any information. Initialing will prevent proceeding with the Family Support Specialist Program.

Information on my child, family, and/or myself may be accessed and used for the purpose of providing and evaluating services or coordinating care for my child, family, and/or myself by state agencies and agencies from other counties who utilize the same statewide electronic health record/database on a need to know basis. Information may be reported in aggregate form on state and local reports.

- ➢ This Release of Information will remain effective, without expiration, until the conclusion of my involvement and the involvement of my child with the Family Support Specialist Program.
- ➢ However, I understand that I have the right to revoke this authorization in writing, by sending/providing such written notification to:

  Stark County Family Council
  Dan Gichevski, Executive Director
  6057 Strip Ave. NW
  North Canton, OH 44720

- ➢ I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law.

This Release of Information has been explained to me. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

_____

Parent/Guardian Signature Relationship to youth Date

_____

Youth Signature Date

_____

Witness Signature Date