SENECA COUNTY CONSENT FOR
RELEASE OF INFORMATION

Person's Full Name _____ Date of Birth _____

Parent/Guardian Name _____

Social Security Number _____ Individual Case Number _____

The following agency (s) have my permission to exchange/give/receive information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person (please identify all agencies that apply):

_____	Seneca Co. Cluster/Council	_____	Tiffin City Schools
_____	Seneca Co. General Health District	_____	Seneca County Head Start
_____	Mental Health & Recovery Services Bd	_____	Fostoria Community Schools
_____	Firelands Counseling & Recovery Services	_____	_____ School
_____	North Central Ohio ESC	_____	Seneca Co. Juvenile Court
_____	Ohio Department of Youth Services	_____	Seneca Co. Job and Family Services
_____	Opportunity Center	_____	Other _____
_____	CASA (Court Appointed Special Advocate)	_____	Other _____

I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual: (Circle yes or no and Initial.)

Yes No _____ Identifying Information; name, birth date, sex race, address and telephone number

Yes No _____ Social Security number

Yes No _____ Case Information: the above Identifying Information, plus medical (except for HIV, AIDS and drug and alcohol treatment records) and social history, treatment/service history, psychological evaluations, Individualized Education Plans (JEP's), Individualized Family Service Plans, transition plans, vocational assessments, grades and attendance, and other personal information regarding me or the individual named above (disability, type of services being received and name of agency providing services to me or the individual named above).

Information regarding the following, shall not be released unless initialed below:

Yes No _____ HIV and AIDS related diagnosis and treatment

Yes No _____ Substance abuse diagnosis and treatment

Yes No _____ Financial Information: Public assistance eligibility, Medicaid, and payment information provided for establishing eligibility including but not limited to pay stubs, W2's 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 revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was canceled.

I understand that my signing or refusing to sign this consent will not affect public benefits or services that I am eligible for.

This consent expires on the _____ day of_____, 20 _____.

_____ _____
Signature of Person Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness/Agency Representative 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.

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 CPR 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.

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

   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.

3. 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.

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