



**FAMILY & CHILDREN FIRST COUNCIL OF ERIE COUNTY  
CLIENT AUTHORIZATION FOR INFORMATION SHARING**

I hereby authorize the member agencies of the Family & Children First Council of Erie County, named on the reverse side of this authorization, to exchange, give, receive, share or redisclose information in their records, from whatever source derived, related to my participation and that of my minor child.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand the following:

1. The purpose of this information sharing is to improve the communication about services to me and my family.
2. Each of the member agencies have agreed:
  - A. To share this information only with other member agencies.
  - B. Not to share information with non-member agencies without consent otherwise required or authorized by law.
  - C. Information exchange due to this authorization will not be used against me or my children for purpose of criminal investigation, prosecution, or sentencing, unless otherwise required by law or judicial order.
3. Any and all right to confidentiality, which I may have under state or federal law will continue, except for information covered by this form.
4. I may revoke this Authorization at any time except for information that has been previously exchanged.
5. This authorization shall automatically expire 180 days from the date below unless I revoke it sooner.
6. This Authorization shall not restrict information sharing otherwise authorized by law.

I authorize sharing of the following information: (circle if yes and sign below)

Yes \_\_\_ Case information: Identify information, plus medical and social history, treatment/service history. Psychological evaluations, IEP's, IFSP'S, transition plans, vocational assessments, grades and attendance, financial information and other personal information held by any on the member agencies regarding me or my minor children.

Yes \_\_\_ Substances abuse diagnosis and treatment

Yes \_\_\_ Child Adolescent Needs and Strengths (CANS) and Electronic Health Record (EHR)

If yes; this authorization for information sharing has been explained to me. I have read the disclosures below. I have been given 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.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian (if applicable) \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Person Signing to Client: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Person Facilitating this Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

If applicable, date of revocation: \_\_\_\_\_

(Revocation must be submitted in writing)

**Member Agencies: (PLEASE CHECK EACH FOR AUTHORIZATION)**

- Erie/Huron/Ottawa County Board of Education (Erie County Schools
- Sandusky City Schools
- Erie County Board Of Developmental Disabilities
- Mental Health & Recovery Board of Erie/Ottawa Counties
- Bayshore Counseling
- Firelands Counseling and Recovery Services
- OhioGuidestone
- Erie County Department of Job and Family Services
- Erie County Family/Juvenile Court
- Ohio Department of Youth Services
- Erie County Help Me Grow
- Erie County Health Department
- Erie/Huron Counties Community Action Commission, Inc.
- Family and Children First Director/Council
- Regional/Local Family Advocates
- Sandusky Artisans Recovery Community Center

I am also authorizing the exchange of information with the following specific persons/agencies:	
_____	_____
_____	_____
_____	_____
_____	_____
Signature of Client (or parent/guardian if applicable)	Date Signed

**Definition of “Case Information”:**

If this release authorizes the disclosure of Case Information, consent to such disclosure may include the following types of information, if it is in files of the agency disclosing this information:

- a. Identifying information: names, birth dates, sex, race, address, telephone number, type of services being received and name of agency providing services to me or my minor children. Medical records, including but not limited to results of physical and mental examinations, diagnosis of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment services received, summary of treatment plans and treatment needs.
- b. Psychological and medical testing, including IQ test or other tests of cognitive or emotional or mental status, and any reports of physical test such as x-rays, CT Scan, diagnostic blood testing, and other test results.
- c. All records of services provided by the Erie County Job and Family Services.
- d. Juvenile court and detention records.
- e. School records. This information is subject to the Family educational Rights and Privacy Act of 1974, 20 USC 1232g, and the Ohio Student Records Privacy Act RC 3319.321.

**To all the agencies receiving information disclosed pursuant to this consent:**

If the records released pursuant to this consent include records of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly pertained by the written consent of the person 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 the information to criminally investigate or prosecute any alcohol or drug abuse patient.