This consent is needed to facilitate, coordinate, plan, fund and provide Service Coordination Services for:

|  |  |  |
| --- | --- | --- |
|  |  |       |
| Name | Date of Birth | Social Security Number |
| 2465 Symingto |  |  |
| Address  | City, State, Zip Code | Phone # |

Only agencies potentially involved in the case will be included in this release.

 **(Please check the relevant agencies.)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Check** | **Organization** | **Check** | **Organization** |
| [ ]  | ADAMH Provider Agencies | **[ ]**  |  |
| **X****[ ]**  | Columbus City Schools | [ ]  | Ohio Department of Youth Services |
| [ ]  | Dept. of Job & Family Services | ￼ | Other Mental Health Provider: St. Vincent |
| ￼ | Franklin County Board of Development Disabilities | ￼X | **Fidelity EHR (FCFC data system)** |
| ￼  | Franklin County Children Services | **[ ]**  | **Other: Franklin County DJFS** |
| **[ ]**  | Franklin County - Court Of Common Pleas Domestic Relations Division A, Juvenile Detention Center | X[ ]  | **Other: Nationwide Children Hospital** |
| **[ ]**  | Franklin County Residential Services | **[ ]**  | **Other:** |

I do NOT want any information shared with the following agencies:

|  |  |  |
| --- | --- | --- |
|       |  |       |

*Franklin County Family and Children First Council shall follow the privacy regulations of the Health Insurance Portability and Accountability Act (“HIPAA”) for use of and protection of the data. All information shall be kept confidential with the exception of any information that would necessitate a referral to child protection services under Ohio Revised Code section 2151.421 (Mandated Reporting Law).*

The following agencies/organizations have my permission to give/receive/exchange/share (Specify extent or nature or information to be disclosed):

**Purpose of Disclosure**: [x]  to coordinate treatment, [x]  to gather assessment information for treatment planning, [x]  to gather information for ongoing treatment, [x]  other purposes: planning, funding and providing Service Coordination

**Type of Information to be Disclosed**: [x]  progress notes, [x]  diagnostic assessment information both mental health and substance abuse, [x]  progress in treatment both mental health and substance abuse

[x]  Educational records [ ]  other information [specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This consent can be revoked by me at any time except to the extent that action has been taken in reliance thereon. I may revoke this authorization in writing by sending a written revocation to:**

**Family and Children First Council, 2760 Airport Drive, Columbus, OH 43219.**

Initial below the option you are choosing.

\_\_\_\_\_

Initial

**This consent is effective as long as the client is receiving services through the Franklin County Family & Children First Council and will expire when FCFC services terminate. This consent may extend past 180 days as long as the forthwith condition has not been met or the consent has not been revoked.**

***\* Choose One***

 **OR**

\_\_\_\_\_

Initial

This consent is valid for 180 days or:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date, event or condition upon which it will expire)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of legal guardian, if applicable Signature of legal guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of client (necessary if an adult) Date Name of Witness Date