AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Individual Served:_____ *Date of Birth*:_____

I authorize SCBDD to:

Release to:_____ *Obtain From*:_____

The following information:

- ☐ Assessment and diagnosis (MFE)
- ☐ Treatment and progress
- ☐ Social History
- ☐ Psychological Test results
- ☐ Other:_____

The following information:

- ☐ Assessment and diagnosis (MFE)(F.E.D.)
- ☐ Treatment and progress
- ☐ Most current IP/ISP/IEH/IHP
- ☐ Psychological Test Results
- ☐ Results of recent physical examination
- ☐ Other:_____

Dates of service to release: (from)_____ (to):_____

The purpose of this disclosure is:

☐ Coordination of care

☐ Requested by Individual Receiving Services, or Guardian/Parent

☐ Other:_____

1) I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by submitting a written request with the date and my signature and delivering it to: SCOC Main Office: 780 E. CR 20, Tiffin, OH 44883 or SSA Office: 40 Fair Lane, Tiffin, OH 44883 or EI Office at 797 E. Twp. Rd. 201, Tiffin, OH 44883
2) I understand that the party receiving my information might not be subject to HIPAA, FERPA, or Ohio confidentiality laws and might be allowed to disclose this information.
3) A copy of this authorization shall have the same force and effect as the original.
4) **Check which of the following is applicable:**
   - ☐ The Seneca County Board of Developmental Disabilities **does not require that I sign this authorization** in order to receive services.
   - ☐ I understand that **if I refuse to sign this authorization, I may not be enrolled for services** in the DD Board because the DD Board cannot get information necessary to determine eligibility for DD Board services.

Check if applicable:

☐ This authorization is for release of protected health information for fundraising or levy purposes. SCBDD may receive funds as a result of using my protected health information.

Expiration Date:

☐ One year from date signed ☐ Other date:_____

_____ _____

Signature Date

If signed by someone other than the Individual being served:

Print Name_____

Authority to sign: ☐ Parent or Guardian

☐ Appointed by Individual as HIPAA Personal Representative

☐ Other: _____

For Office Use Only:

Staff person releasing information (print name)_____

(signature)_____

Date Information Released:_____