Council for Union County Families (Revised 3/2024)
Authorization for Release/Exchange of Information

Caregiver's Name:	
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:

_____, being the Custodial Parent or the Legal Guardian or the Legal Representative of the Public Agency having custody of the youth listed above, authorize the Member Agencies of the Council for Union County Families (CUCF) to release necessary records of the above named child(ren)/family to the CUCF, and for the CUCF and its members to discuss the records and the information in the records for the purpose of developing a Coordinated Plan.

- I understand these records will be entered in an electronic health record including additional enrollment in an electronic billing system.
- I further understand these records are protected under Federal and State laws governing Confidentiality of Patient, Student, and Client Records, and cannot be disclosed or re-released without my written consent unless otherwise provided for the regulations.
- I acknowledge my child may be eligible and enrolled in OhioRISE and information may be exchanged with the Ohio Department of Medicaid, Aetna Better Health of Ohio, and Harbor Health.
- I agree to the use of telehealth platforms for video conferencing. Please note third-party applications potentially introduce privacy risks.
- I hereby release the CUCF from all legal responsibility or liability that may arise from this authorization.
- I understand that all employees of CUCF are mandated reporters per Ohio Revised Code (Section 2151.421) and are required to report any suspicion or knowledge of abuse, neglect, or safety concerns.
- I understand I can revoke the authorization at any time, except to the extent that action has been taken in reliance thereon, by giving written notice to the CUCF. This authorization (unless expressly revoked earlier) expires itself one year from when services end.

Parent/Guardian Relationship Date

Signature of Witness Date

Agencies and Practitioners
Authorized to Release/Exchange Confidential Information

- ☐ Maryhaven
- ☐ OhioGuidestone
- ☐ Chrysalis Health
- ☐ The Hope Center
- ☐ Nationwide Children's Hospital
- ☐ School system: _____
- ☐ Board of DD
- ☐ Early Intervention/Help Me Grow
- ☐ Multi-System Youth Review Team
- ☐ Mental Health Recovery Board of Union County
- ☐ Department of Youth Services
- ☐ Union County Juvenile Court and Probation
- ☐ Union County Department of Job and Family Services/CPS
- ☐ Police Department: _____
- ☐ Union County Sheriff
- ☐ Other(s) Please List: _____

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my child and me:

1. Records of services provided by any of the above-mentioned agencies or entities.
2. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional functioning or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, or other test results.
3. Medical records including, but not limited to, results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment or services received, summary of treatment plans and treatment needs, social history, education history, involvement with juvenile justice, and financial information.
4. Drug and alcohol abuse diagnoses and treatment including, but not limited to, results of evaluations, diagnoses, treatment and services received, treatment plans and treatment needs. (This information will be disclosed ONLY IF INITIALED here to permit such release _____).
5. Any information regarding HIV and AIDS diagnoses and treatment. (This information will be disclosed ONLY IF INITIALED here to permit such release _____).
6. Treatment summaries and recommendations from above-mentioned agencies or entities.

NOTICE: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice of Cancellation: Date: _____ Time: _____
Type of Cancellation: Phone ____ Letter ____In Person ____ Text/Email____
Signature of person requesting Cancelation: _____