Multi-System Youth Technical Assistance and Funding
RELEASE OF INFORMATION

Child/Youth Name	
Date of Birth	Social Security Number

I, _____, authorize the release of all information, including substance use disorder information if applicable, required for service coordination, funding reviews and program evaluation of the Multi-System Youth Program process to be exchanged between and among the following organizations, including all members of the Ohio Family and Children First Council Cabinet and/or his or her designee(s), and staff from the Office of the Ohio Governor:

All member agencies of the Ohio Family and Children First (OFCF) Governor's Children's Cabinet per section 121.37 of the Ohio Revised Code, including The Ohio Department of Medicaid and its contractors.

All of the following _____county and local organizations

- Board of Developmental Disabilities (DD)
- Juvenile Court
- Department of Job and Family Services
- Public Children's Services Agency
- Alcohol Drug and Mental Health (ADAMH) Board
- Family and Children First Council
- OhioRISE Care Management Entity

And all the following organizations (please name applicable organizations below):

Educational Service Center
Residential/In-Patient Facility
School District of Residence & Attendance
Behavioral Health Provider(s)
In-home service provider(s)
OhioRISE CME
Medicaid Managed Care Entity or Entities
Other
Any exceptions or exclusions for information released

Please Initial:

_____ I understand and acknowledge that this authorization extends to all or any parts of the record designated above, which may include treatment for mental illness, and/or alcohol/drug abuse/dependency, AIDS/HIV, and/or educational records. I understand that this information will be released only to the participating agency representatives and that any information released to such representatives may not be further disclosed or shared with any person(s)/organization(s) specifically listed on this form without my written, prior authorization, unless:

- Required to do so by federal and/or state law or regulation
- Unless an emergency exists
- Unless permitted by this or other policies of the _____ Family and Children First Council, or
- Unless the information has been sufficiently de-identified that the recipient would be unable to link the information to the client.

I understand that these records are protected by state and/or federal confidentiality regulations and cannot be disclosed without my written consent, unless provided for in the regulations.

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information to whom it pertains or as otherwise permitted by 42 C.F.R. 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

_____ I do not consent to the disclosure of any information *(will prevent proceeding the Multi-System Youth Program and Funding)*

1. This authorization will remain effective as long as the MSY program is active, unless an earlier date or condition/event is specified here _____. This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

2. However, I understand that I *HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING*, by sending/providing such written notification to ATTN: Multi-System Youth (MSY) Administrator; 50 West Town Street, Suite 400; Columbus, Ohio 43215.

3. I understand that I have the right to refuse to sign this authorization; however, should I refuse to sign the authorization, the child or youth listed above will not be eligible for financial assistance from the Multi- System Youth Program.

4. I have the right to inspect or copy the protected health information and protected educational information to be used of disclosed as permitted under law.

I have read or have had this document read to me and I understand its content.

_____

Signature of Parent or Guardian Date

_____

Relationship to Child or Youth

_____

Name of Child or Youth Date

_____

Signature of Child or Youth if information regarding SUD is involved Date

_____

Witness Date

****A copy of this signed authorization shall have the same force and effect as the original.**

***42 CFR part 2 prohibits unauthorized disclosure of these records.

LEGIBLE SIGNATURES ARE REQUIRED ABOVE.