HOLMES COUNTY
Board of Developmental Disabilities
supporting people in living meaningful lives

AUTHORIZATION FOR RELEASE OF INFORMATION

To: _____
Name and Address

I authorize the release of information for: _____
Person's name

_____
Address City State Zip Code

Date of Birth: _____ Last 4 digits of SS#: _____

The information marked may be released in: _____ Writing _____Verbally _____and/or by electronic media **(check all that apply)**

Amount of information to be released: _____ **Past three (3) Months;** _____ **Most recent admission/visit;** _____ **other time period/amount of information** _____

_____Diagnosis	_____Medication(s) Prescribed and reason	_____Lab Results for: _____
_____Progress Notes	_____School/Educational Records	_____
_____Summary of Contact(s)	_____Reunification Plan	_____Discharge Summary/Date: _____
_____Summary of Records	_____Conditions of Probation	_____ER Discharge Summary/Date: _____
_____Drug and Alcohol Use	_____Psychological Test Results/Evaluation	_____ Other/Specify: _____
_____Eligibility documentation	_____OEDI/COEDI, FEDs and/or LOC	_____
_____Behavior support plan	_____Letter of guardianship	_____Copy of birth certificate

This information is for the purpose of: _____

_____

This information has been explained to me and I understand that information cannot be disclosed without my expressed written consent. I understand and acknowledge that this authorization extends to any or all of the record above, which may include treatment for mental health/psychiatric; alcohol abuse, drug abuse, and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome), and other infectious disease(s) test results or diagnosis. Consent of this release expires within one (1) year from date of signature unless otherwise specified. A photocopy of this release of information is as valid as the original. I understand that the information will not be re-released by the Holmes County Board of DD without my consent except as permitted by law. I further understand that information used or disclosed pursuant to this authorization to another recipient may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

8001 TR 574
Holmesville OH 44633

www.holmesdd.org

(330) 674-8045
(330) 674-5182 (fax)

The above marked information/records may be **released to**:

Name (of representative) for | Name of school, agency, doctor, specialist

Address | City | State | Zip Code

I certify that (check one):

_____ I am the subject of these reports and am eighteen (18) years of age or older.

_____ I am the parent, guardian, or custodian of the subject of these reports and the subject is under eighteen (18) years of age.

_____ I am the guardian of the subject of these reports and the subject is eighteen (18) years of age or older.
Court Docket Number from Guardianship Proceedings _____

1. This information has been disclosed 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 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.
2. A photocopy of this Release of Information is as valid as the original.
3. My receiving services will NOT be conditioned on whether I provide authorization for the requested use or disclosure.
4. I understand I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected personal or health information to be used or disclosed as permitted under law.

Signature of Person/Parent/Legal Guardian/Custodian | Date

Signature of Person Releasing Records/Information | Date Released

My permission is extended only for the purpose as stated on this authorization for One Year from date signed. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Service & Support Administration, Holmes County Board of DD, 8001 TR 574 Holmesville, OH 44633. I understand that a revocation is not effective to the information released or received prior to the revocation received by HCBMRDD.

I hereby revoke consent of this release of information:

Signature | Date

TJK/DOCS/Revised 7/20/2016

8001 TR 574
Holmesville OH 44633

www.holmesdd.org

(330) 674-8045
(330) 674-5182 (fax)