Consent to Release, Obtain, and Utilize Information

Client's Name ______________________________ DOB ______________

The purpose of court involvement is to improve the well-being of youth and to ensure community safety. To accomplish this, the court depends upon the use of accurate, complete information. The information collected is only shared with other agencies with a parent or guardian's consent for the benefit of service coordination and service collaboration for the child and family. If information gathered is used for program analysis or research purposes, the information is de-identified, and stored as anonymous information as to not be able to tie information to an individual child or family. This is vital to ensure the court is able to prove the effectiveness of its programming.

Check all that apply:

I authorize release of information from Summit County Juvenile Court, 650 Dan St., Akron, OH 44310 to:		I authorize the release of information to Summit County Juvenile Court, 650 Dan St., Akron, OH 44310 from
	Child Guidance & Family Solutions	Child Guidance & Family Solutions
	Children's Hospital Medical Center of Akron	Children's Hospital Medical Center of Akron
	County of Summit Developmental Disabilities Board	County of Summit Developmental Disabilities Board
	District and School (specify):	District and School (specify):
	Greenleaf Family Center	Greenleaf Family Center
	Lighthouse Family Center	Lighthouse Family Center
	Minority Behavioral Health	Minority Behavioral Health
	Oriana House, Inc.	Oriana House, Inc.
	Red Oak Behavioral Health	Red Oak Behavioral Health
	Shelter Care/Safe Landing	Shelter Care/Safe Landing
	Summit Co. Alcohol, Drug Addiction Mental Health Srvcs	Summit Co. Alcohol, Drug Addiction Mental Health Srvcs
	Summit County Children Services	Summit County Children Services
	Summit County Family Children First Council	Summit County Family & Children First Council
	Summit County Juvenile Court Staff	Summit County Juvenile Court Staff
	Summit County Juvenile Court Clinical Staff	Summit County Juvenile Court Clinical Staff
	Summit Psychological Associates	Summit Psychological Associates
	Village Network	Village Network
	Other (specify):	Other (specify):
	Other (specify):	Other (specify):
	Other (specify):	Other (specify):

________ I (parent/guardian) agree to allow this form to be sent to the above selected agencies and to disclose my involvement with selected agencies.

________ I (youth) agree to allow this form to be sent to the above selected agencies and to disclose my involvement with selected agencies.

Reason for Release of Information Includes: (check all that apply)

	Communication with Family/Significant Other		Preparation of Vocational Rehabilitation Report
	Continuity of Care/Provision of Treatment		Development of court recommendation/planning
	Preparation of Diagnostic Assessment		Share information identified below with above selected agencies at planning meetings for my child
	Disability Determination		
	Other (specify):		Other (specify):

Information to be disclosed: (check all that apply)

	Diagnostic Information		Evaluation/Assessments		Psychosocial History
	Treatment Plan		Recommendations		Ongoing communication to Facilitate Services
	Alcohol and or Other Drug Treatment/Assessment		Treatment Outcomes		
			Other (Specify):		
	Mental Health Treatment/Assessment		Other (Specify):		

This authorization has been fully explained to me and I understand it. I understand that if the person(s) receiving the information are not health care providers covered by Federal privacy regulations, the protected health information they receive may be further used or disclosed by them and may not be protected any longer by the Federal privacy regulation. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC §5122.31), alcohol, drug use and or abuse (42 CFR Part 2) and/or Human Immunodeficiency Virus test results or diagnoses. (ORC §3701.243).
I understand that I may revoke this authorization by providing written notice to the releasing agency/individual at any time except to the extent that action has already been taken in reliance on it and I also understand that the authorization period can be modified by me.
I voluntarily consent to the release of designated information. I understand my records may be protected under the federal and state regulations governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 CFR Part 2, 20 USC 1232g, ORC §2151.14, ORC §3701.243, and ORC §5122.31)
I understand that treatment, payment, enrollment, and/or eligibility for benefits does not depend on my signing this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Unless otherwise contained in this document this consent expires automatically upon the completion of court involvement.

*Note: Release of information for mental health records may be valid for a maximum of one year; however, release of information for alcohol/drug treatment records may be valid for the duration of involvement. *

Youth Signature ____ Date______

Parent or Guardian Signature: ______________________________________ Date______

Specify Relationship to Youth: ______________________________________ Date______

Witness Signature: ____ Date______

**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 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. Ohio law (Mental Health 5122.27.09), (HIV/AIDS 3701.24.3) also prohibits further disclosure of this information without the specific written consent of the person to whom it pertains. These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure. **

I hereby revoke this authorization for exchange of information or limit the exchange of information in the following way:

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______________________________________ ______________________________

Youth or Parent/Guardian Signature Date