Cuyahoga County Court of Common Pleas
Juvenile Court Division

AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose of Form and Uses of Information: This authorization allows the noted systems and providers to share information about the child named below. Information will be used to provide assessment and/or treatment services for the youth.

PLEASE PRINT CLEARLY

Child's Name		Date of Birth (mm/dd/yyyy)
Address:		Home Telephone number
City	State/Zip	Cell Phone number

✓ the EXC box to consent to 2-way sharing OR
Write (DIS) in the EXC box if only disclosing information OR
Write (REC) if only receiving information.
Identify the child's school/district and any other systems or private providers whose information might help to provide better services.

EXC	
	Cuyahoga County Juvenile Court Staff
	Cuyahoga County Juvenile Court Early Intervention and Diversion Center
	Applewood Centers, Inc.
	Beech Brook
	Bellefaire JCB
	Catholic Charities Corporation
	Cuyahoga County Division of Children & Family Services (CCDCFS)
	Cuyahoga County Board of Developmental Disabilities
	Cuyahoga County Family Centered Support Services (formerly know as Tapestry System of Care)
	ADAMHS Board of Cuyahoga County
	OhioGuidestone
	Murtis Taylor
	PEP Connections
	The Village Network
	OhioRise
	Other (Please specify)
	Other (Please specify)
	Other (Please specify)
	School/School District

Information to Be Exchanged*:* *(Initial all that apply)*

__ __ Identifying Information*: (Name, birth date, sex, race, address, telephone number)*
__ __ Social Security Number, UCI number if any *(for Medicaid purposes)*
__ __ Education Records, per 34 CFR Part 99
__ __ Mental Health Records: Personal/social history, Psychological/Psychiatric Assessments, Evaluations, Treatment & Service History
__ __ Juvenile Court records
__ __ Medical Records – records of health care providers related to general health *Except HIV, AIDs and drug and alcohol treatment)*
__ __ AIDS/HIV diagnoses, tests and other communicable diseases, as permitted by state and federal law
__ __ Alcohol and/or Drug Abuse Treatment records as permitted by state and federal law *(42 CFR Part 2)*
__ __ Financial Information necessary to establish eligibility for public assistance. *(This may include pay stubs, W-2 and tax return information, and other general financial information.)*

Revised 8/12/2020

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AUTHORIZATION

- I authorize the checked systems and providers to exchange/disclose/receive the initialed information about the child identified above for the reasons noted.
- I understand that signing or refusing to sign this consent will not affect public benefits or services for which the child or I are eligible, unless otherwise required by law.
- **Expiration:** I understand that this authorization will expire in 12 months, **unless I limit the time frame or cancel this authorization in writing** _ _____
  Initials

  Or I choose to limit the time frame to the following date: ___ _________________.
- I understand that canceling this authorization does not apply to any information already shared in reliance on this authorization

__ ______________________________ ______________________________ _ ___
Printed Name: Parent/Legal Guardian Signature Date

__ ______________________________ ______________________________ _ ___
Printed Name: Child/Youth (if 12 years of age or over) Signature Date

_ ______________________________ ______________________________ _ ___
Printed Name: Witness/Agency/System Signature Date

Information used or disclosed may be subject to redisclosure and may no longer be protected under federal law.

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED UNDER THIS AUTHORIZATION

1. If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:

   PROHIBITION
   ON REDISCLOSURE OF INFORMATION CONCERNING CLIENTS IN ALCOHOL OR DRUG ABUSE TREATMENT.

   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.

2. **HIV RECORDS:** If the records released include information of an HIV-related diagnosis or test results, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.

3. **ALL RECORDS:** The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release is prohibited unless expressly permitted by the person to whom it pertains, by Juvenile Court/DYS in the case of youth records, or under applicable federal and/or state law.

CANCELLATION

I, the parent/legal guardian named above, wish to cancel this authorization effective as of this date: ____________.

Signature of Parent/ Guardian: _____________________________________Witness Initial______________