Cuyahoga County Board of Developmental Disabilities

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Consumers Full Name _____ Date of Birth _____

Social Security Number _____ Case Number (Optional) _____

I authorize:

☒ Cuyahoga County Board of Developmental Disabilities 1275 Lakeside Avenue East Cleveland, OH 44114

☒ Cuyahoga East Vocational Education Consortium (CEVEC) 1111 SOM Center Road Mayfield Heights, OH 44124

☒ School district of residence and/or placement

☐ _____

To disclose specific information, including identifiable health information, for the following specific

Purpose(s); **Eligibility Determination for Transition Services** _____

_____

To the following persons/programs/agencies/school districts:

☒ Cuyahoga County Board of Developmental Disabilities 1275 Lakeside Avenue East Cleveland, OH 44114

☒ Cuyahoga East Vocational Education Consortium (CEVEC) 1111 SOM Center Road Mayfield Heights, OH 44124

☒ School district of residence and/or placement

☐ _____

INFORMATION BENING RELEASED

yes _____ Identifying Information: name, birth date, sex, race, address and telephone number
yes _____ Social Security Number
yes _____ Other identifying records; birth certificate, social security card, guardianship and other court documents
yes _____ General Medical: medical records (except for HIV, AIDS and drug and alcohol treatment records) including but not limited to lab results, physicians' orders, medical history, physicals and disability diagnostics,
yes _____ Behavioral Health Records; including but not limited to Psychiatric Examinations, Social Work Release Summaries, Social Work Assessments, Consultations, Diagnostic assessments, Psychological Evaluations and other psychological or behavioral assessments and reports

yes _____ School Information: grades, attendance records, Multi-Factored Evaluation (MFE) and transition plans
yes _____ Service Plan Information; including but not limited to Individualized Education Plans (IEP), Individualized Family Service Plans (IFSP), Individual Service Plans (ISP), Individual Plans (IP), Core Plans, Action Plans and addendums, type of services being received and name of agency providing services
yes _____ Assessments; including but not limited to vocational, service planning, and financial

yes _____ **Status of Eligibility for County Board Services (In Process or Eligible or Not Eligible)**
yes _____ Progress notes
yes _____ HIV and AIDS related diagnosis and treatment.
yes _____ Current substance abuse treatment, recommendations and involvement specifically,
yes _____ Financial Information necessary to establish eligibility for public assistance including but not limited to pay stubs, W2's and tax returns, and other financial information.
yes _____ Other Information

NOTIFICATIONS

I understand that I may cancel this Authorization at any time providing a dated and written statement with my signature to the Cuyahoga County Board of Developmental Disabilities (CCBDD) at the address listed above. Canceling this Consent will become effective the date of the cancellation and will apply to that day forward and not to information already shared.

I understand that if I have authorized the CCBDD to disclose my protected health information to persons who are not required by Federal or State law to keep the information confidential, these persons who are receiving the records may disclose my protected health information to others without my consent or authorization.

I understand that I have the right to inspect and copy the protected health information to be used or disclosed as permitted under Federal of State law.

I understand that my alcohol and drug abuse patient records are protected under the Federal regulations governing confidentiality of those records, (42 CFR Part 2), cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that signing or refusing to sign this Authorization will not affect public benefits or services for which I am eligible.

EXPIRATION DATE

This authorization will expire one year after the date on which this authorization is signed.

(Insert date or event of expiration: for mental health records, the date cannot exceed six months unless the consumer who is the subject of this authorization agrees to a date beyond six months on this line. Authorizations executed for research studies shall expire at the end of the approved study. For all other authorizations the event or date of expiration shall not exceed one year.)

NOTICE RELATED TO DRUG & ALCOHOL, HIV RECORDS

TO ALL AGENCIES SENDING AND/OR RECEIVING INFORMATION DISCLOSED AS A RESULT OF THIS SIGNED CONSENT:

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

EXECUTION

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

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Personal Representative's Signature Date

_____ _____
Witness/Agency Representative Signature Date

Explanation of the Representatives authority to act on behalf of the consumer:

_____

_____

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Revised 10/7/13