Region 16 Universal Release Form
Consent to Release Confidential Information

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| Issuing Agency: |  County: |  Date:  |
|   |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Participant Name: |  DOB: | SS#: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please indicate, “All of the following”, or initial the individual agencies with whom you wish to share information.I, hereby authorize: |
| \_\_\_ All of the following |
| \_\_\_O.S.U. Extension | \_\_\_ Mental Health | \_\_\_ One-Stop |
| \_\_\_ Early Start | \_\_\_Probate Juvenile Court | \_\_\_ Red Cross |
| \_\_\_ School Districts | \_\_\_Physicians | \_\_\_ Sheriff |
| \_\_\_ Board of MRDD | \_\_\_Community Action | \_\_\_ Police Department |
| \_\_\_ Head Start | \_\_\_ Bureau of Support | \_\_\_ Prosecutor |
| \_\_\_ Job & Family Services | \_\_\_ Recovery Programs | \_\_\_ Victim/Witness |
| \_\_\_ Children’s Services | \_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_Adult Probation |
| \_\_\_ Health Department | \_\_\_Domestic Violence Programs | \_\_\_Adult Parole |
| \_\_\_Rehabilitation Services Commission | \_\_\_ Veteran’s Services | \_\_\_VA Chillicothe |
| \_\_\_Vocational/Educational Services | \_\_\_Goodwill Industries | \_\_\_ Commission on Aging |
| \_\_\_ Early Intervention | \_\_\_ Employment Services Program | \_\_\_Alternative School |
| \_\_\_Service Plan Coordinator | \_\_\_ Metropolitan Housing Authority | \_\_\_Nursing Home |
| \_\_\_Legal Services | \_\_\_ Transportation | \_\_\_Employer |
| \_\_\_Family & Children First | \_\_\_ Pregnancy Center | \_\_\_Landlord |
| \_\_\_Continuum of Care | \_\_\_ Food Pantry  | \_\_\_CLUSTER |
| \_\_\_Potential Housing Providers | \_\_\_ Region 16 Coordinated |  |
| \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake Partners |   |
| There may be a need to share documents, as necessary to develop an effective service plan, avoid duplication of services to, or better assess the needs of the household. Such documents may include: |
| \_\_\_All of the following | \_\_\_Housing Information | \_\_\_Medical Records |
| \_\_\_Psychotherapy Reports | \_\_\_Psychological Reports | \_\_\_Service Records |
| \_\_\_Scholastic/Attendance Reports | \_\_\_Court Records | \_\_\_Employment Information |
| \_\_\_Arrearages | \_\_\_Individual/Family Service Plans | \_\_\_Individual/Family Case or Goal Plans |
| \_\_\_Individual/Family Referrals | \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_Only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| Specify where required by confidentiality laws and regulations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| By signing this form, I understand that papers may contain private information about me and my children and that I am allowing this information to be shared by those indicated above. I also understand that the information released is protected by State and Federal confidentiality regulations and cannot be disclosed without my written consent. I further understand that I may revoke this consent at any time. This consent automatically expires one year after the day of the signature. |
| Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_\_Father |  \_\_\_Mother |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Revoked date: \_\_\_\_ -\_\_\_\_ -\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_\_Father |  \_\_\_Mother |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Renewal Date: \_\_\_\_ - \_\_\_\_ -\_\_\_\_\_ | Signature: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |
| Please Indicate: |  \_\_Father |  \_\_Mother  |  \_\_\_Legal Guardian | \_\_\_Self |  \_\_\_Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |