Region 16 Universal Release Form  
Consent to Release Confidential Information

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
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| 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |