SCIOTO COUNTY FAMILY AND CHILDREN FIRST

SHARING OF INFORMATION FORM

Client Full Name _____ Date of Birth _____

The following agency(s) have my permission to share/give/receive/exchange/re-disclose information regarding service delivery planning for the purposes of securing, coordinating and/or providing services for the above named youth. Please identify all agencies that apply.

☐ DJFS _____ ☐ Referring Agency- _____

☐ Medical Dr - _____ ☐ School - _____

☐ Psychiatrist/Counselor - _____ ☐ Other- _____

I authorize sharing/giving/receiving/exchanging/re-disclosing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the youth:

Check yes or no and initial for both:

☐ Yes ☐ No	_____	Identifying information: name, birth date, sex, race, address and telephone number.
☐ Yes ☐ No	_____	Social security number
☐ Yes ☐ No	_____	General medical: medical records
☐ Yes ☐ No	_____	Social History: social history, treatment/service history, psychological evaluations, and other personal information regarding youth.
☐ Yes ☐ No	_____	Department of Job and Family Services
☐ Yes ☐ No	_____	School Information: attendance records, Individualized Educational Plan (IEP) and any other pertinent records.
☐ Yes ☐ No	_____	Date of discharge and discharge status/discharge plan
☐ Yes ☐ No	_____	Education and training related information

Purpose for which the information may be requested and will be used:
Share all case related information pertaining to child related to previous treatment/services for the purpose to ensure wellbeing of child in care. Information to be shared is all information related to this child – Medical Dr/Psychiatrist/Counselor – all diagnostic information, testing, prescriptions, SA/MI information – course of treatment, etc. School – share information re: enrollment, academics, behaviors, attendance and any other school related information. All information will be disclosed to Service Coordinator (Director of Family Outreach) to ensure the child is receiving the best possible treatment while participating in service coordination.

I understand that the Sharing of Information Form expires one year from the date of the initial signing if signed at intake or 90 days from the date of signing if signed at a time other than intake. I also understand that I may revoke this Sharing of Information Form at any time by stating so in writing with the date and my signature and delivering it to Family and Children First Service Coordinator. The revocation does not include any information which has been shared between the time that I gave permission to share information and time that it was cancelled.

This Sharing of Information Form expires on the _____day of _____, 20__.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (if necessary) Date

_____ _____
Agency Representative Date

Note: Authorization is not required to share information permissible under federal laws and regulations or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.

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

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

    •Information disclosed pursuant to this Sharing of Information Form has been disclosed to you from records whose confidentiality is protected by Federal Law.

    •Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

2. If the records released include information of 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 diagnosis.

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 person to whom it pertains, or applicable federal and/or state law expressly permits the further disclosure.

USER CHECKLIST

1. Explain that the form is voluntary not mandatory.

2. Explain the purpose of the form, which is to expedite services for individuals requiring services from more than one agency.

3. Explain that not signing it will not result in a refusal of services, but could result in a delay of services.

4. Review all parts of the Form with the youth and guardian and explain the purpose of each part.

5. Review the specific information noted in the Form, which the guardian may authorize to be shared.

    - Make it clear to the guardian that he/she can authorize release of all data listed or only some as he/she chooses.

    - Explain how guardian who decides to authorize release of only a portion of the information makes this known by checking yes or no as appropriate if it is an entire category such as financial information.

    - Explain that the guardian can authorize release of only a portion of information in a category by crossing out information they do not want to be shared.

6. Inform the person that he or she can revoke the form at any time for any reason, by stating so in writing to the coordinating agency.

7. Explain that the Form is valid for up to one year, unless revoked sooner. Ensure the person understands that when the Form expires, agencies can no longer share information unless the guardian executes a new form.

8. If the person whose records are to be released is a minor, ensure that the guardian understands the Form, completes it and signs it. Without this process and signature, the Form is not valid.

9. Ensure the person is briefed on the law stating that sharing of information regarding HIV related diagnosis information, substance abuse and diagnosis and treatment information. If the person believes completing the Form will expedite services to them, ask them to complete it.

10. Note if child abuse or neglect records are needed, they may only be released with the written permission of Family and Children First Service Coordinator.

11. Encourage the person to know what records are in his/her health records before authorizing the Form.