GEAUGA COUNTY BOARD OF COMMISSIONERS

Tracy A. Jemison Mary E. Samide William S. Young

DEPARTMENT OF JOB AND FAMILY SERVICES *Tim Taylor, Director*
12480 Ravenwood Drive, P.O. Box 309, Chardon, Ohio 44024

GEAUGA COUNTY JOB AND FAMILY SERVICES
CONSENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ give the following agencies and/or persons my permission to release and/or obtain information about myself and/or my family _____. Communication may be written
(Self/Family member's name)
and/or verbal. My **initials** indicate those agencies I give permission to release and/or obtain information about myself and/or my family.

_____	Ravenwood Mental Health Center	_____	Lake/Geauga Center	_____	North Coast Counseling
_____	Catholic Charities	_____	Neighboring	_____	Crossroads
_____	Woman Safe	_____	Windsor-Laurelwood	_____	Parent Project
_____	Help Me Grow	_____	Health District	_____	Metzenbaum
_____	Court	_____	Youth Center	_____	Bridges/Junior Bridges
_____	Doctor/Hospital (specify) _____			_____	Probation
_____	School (specify) _____			_____	Family First Council
_____	Other (specify) _____			_____	Geauga County JFS

_____ Initials — I understand that such information released and/or obtained may include the complete case history as shown by the records and any other information related to me and/or my family's physical, medical, mental health, chemical dependence, emotional and/or social condition.

_____ Initials — I understand that the information is to assist Geauga County Job and Family Services in monitoring compliance and progress toward achieving goals outlined in the case plan as well as to assist in the planning of services.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by federal and State law. 42 C.F.R. Part 2, Section 5122.31 and/or Section 3701.243 of the Ohio Revised Code prohibits you from making any further disclosure of it without the specific written and informed release of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This consent and authorization will remain valid for 180 days from the date of the client's signature unless an earlier date is specified. This consent and authorization may be revoked by me in **writing** at any time. It must be signed, dated, and delivered to 12480 Ravenwood Drive, Chardon, Ohio 44024. Canceling it applies to that day forward and not to information already shared.

HIPAA (Health Insurance Portability and Accountability Act) "covered entities" may not condition treatment, payment, enrollment or eligibility for benefits on whether this consent and authorization is signed.

Authorization Date: _____ Expiration Date: _____

_____	_____	_____
Signature	Relationship	Date
_____	_____	_____
GCJFS Staff Signature or Witness	Relationship	Date