_____

Child/Youth Name

**Family & Children First Council of Trumbull County**
**Wraparound Release of Information**

I, _____(Parent/Guardian), hereby authorize the agencies and entities, which comprise the Family & Children First Council of Trumbull County Executive Board, Trumbull County Family Wraparound Oversight Committee, Wraparound Team, and/or Multi-System Youth Review Team to exchange information (from whatever source derived) related to both my own participation and that of my minor child(ren) in the Wraparound process.

I understand that the following identified agencies may be contacted. (*Complete table with the organizations of additional Wraparound team members, including the school district and MCO/insurance provider.)*

| | | | | | |
|---|---|---|---|---|---|
| X | Family & Children First Council of Trumbull County | X | Trumbull County Board of Developmental Disabilities | X | Trumbull County Children Services |
| X | Trumbull County Combined Health District | X | Trumbull County Dept. of Job and Family Services | X | Trumbull County Educational Service Center |
| X | Trumbull County Family Court | X | Trumbull County Mental Health and Recovery Board | X | Alta Care Group |
| X | Belmont Pines Hospital | X | Cadence Care Network | X | Coleman Health Services |
| X | Valley Counseling Services | X | Warren City Schools | X | Local Parent Peer Supporters/ Family Reps |
| X | OhioRISE | | Other: | | Other: |

**_____ If initialed here, I agree to the use of telehealth platforms for videoconferencing between myself, my family, my child, the Family & Children First Council of Trumbull County and the agencies above. Please note that third-party applications, such as Zoom, Microsoft Teams, etc., potentially introduce privacy risks.**

**_____ If initialed here, I acknowledge that my child may be eligible for OhioRISE and information may be exchanged with the Ohio Department of Medicaid, Aetna Better Health of Ohio, and Cadence Care Network, the local Care Management Entity (CME).**

The purpose of the sharing of this information is to coordinate, plan, review and evaluate the services and supports provided by the Family & Children First Council of Trumbull County.

I understand the following (if applicable):

1. The purpose of this information sharing is to facilitate the referral for and coordination of treatment services and to evaluate the effectiveness of these services for my child, family, and/or myself.
2. Any and all rights to confidentiality that I may have under state of federal law will continue, except for information covered by this form.
3. The Ohio Automated Service Coordination Information System (OASCIS), through Ohio Family and Children First, will be used to collect and analyze data on youth/families served through Wraparound.
4. An electronic health record data system through Cadence Care Network, the local CME, will be used to collect and analyze data on children/families served through OhioRISE.
5. The Child and Adolescent Needs and Strengths (CANS) tool is an assessment used by the Family and Children First Council of Trumbull County. The CANS assessment may be entered into the statewide CANS IT database.
6. Any information related to the status of HIV or AIDS confirmation will not be released without a written authorization to share the information specifying to whom and for what intended purpose.
7. I may revoke this Authorization at any time except related to information that has been previously exchanged.

8. This Release of Information shall not restrict the sharing of information otherwise authorized by law.
9. All reports and publications of findings related to the evaluation of services received will not reveal my name or that of my family members, and all information and results will be presented in group format.
10. Information disclosed pursuant to this release is subject to redisclosure by the recipient of the information and may no longer be protected by HIPAA once redisclosed. However, any privacy laws applicable to the entity to whom the information is disclosed will continue to apply.

**Information on my child, family, and/or myself may be accessed and used for the purpose of providing and evaluating services or coordinating care for my child, family, and/or myself by state agencies and agencies from other counties who utilize the same statewide automated databases on a need-to-know basis. Information may be reported in aggregate form on state and local reports.**

_____ _____

Name of the Child/Youth Date of Birth

_____ _____

Name of Parent/Guardian Name of Parent/Guardian

Check one:

☐ This Release of Information covers the length of my involvement and the involvement of my child with the Family & Children First Council of Trumbull County, without expiration.

☐ I request that this Release of Information be reviewed and re-signed on _____ (date) or in _____ months from the original date.

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my child and me:

1. Records of services provided by any of the above-mentioned agencies or entities.
2. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional functioning or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, or other test results.
3. Medical records including, but not limited to, results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment or services received, summary of treatment plans and treatment needs, social history, education history, involvement with juvenile justice, and financial information.
4. Drug and alcohol abuse diagnoses and treatment including, but not limited to, results of evaluations, diagnoses, treatment and services received, treatment plans and treatment needs. (This information will be disclosed ONLY IF INITIALED here to permit such release _____).[1]
5. Any information regarding HIV and AIDS diagnoses and treatment. (This information will be disclosed ONLY IF INITIALED here to permit such release _____).[2]
6. Treatment summaries and recommendations from above-mentioned agencies or entities.

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[1] Information disclosed pursuant to this authorization has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit further disclosure of alcohol or drug related diagnosis or treatment information 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, 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] Information disclosed pursuant to 45 CFR 103 privacy rule. No information will be released regarding HIV/AIDS diagnosis and/or treatment without specific written consent to 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.

AGREEMENT:

This Release of Information has been explained to me. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

_____ _____

Signature of Child (optional) Effective Date

_____ _____

Signature of Parent/Guardian Effective Date

_____ _____

Witness Effective Date

☐ I revoke this release of information effective _____ for ☐ all listed entities ☐ for entities listed below:

_____

REFUSAL:

Initial and sign below:

_____ I refuse to allow my case information to be exchanged. I understand that my signing or refusing to sign this authorization will not affect public benefits or services to which I am otherwise entitled; however, I understand that my refusal to sign this authorization means that the Family and Children First Council of Trumbull County will be unable to provide service coordination or Wraparound support to my youth and family.

_____ _____

Signature of Child Effective Date

_____ _____

Signature of Parent/ Guardian Effective Date

_____ _____

Witness Effective Date