Authorization Form

Holmes County Board of Developmental Disabilities

Holmes County Board of DD
8001 Township Road 574
Holmesville, OH 44633
330-674-8045

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Individual Served _____ Date of Birth _____

I authorize HCBDD to:

Release to: _____
The following information:
___ Assessment and diagnosis (MFE)
___ Treatment and progress
___ Social History
___ Psychological Test results
___ Other _____

Obtain from: _____
The following information:
___ Assessment and diagnosis (MFE) (F.E.D.)
___ Treatment and progress
___ Most current IP (ISP, IEP, IHP)
___ Psychological Test results
___ Results of recent physical examination
___ Other _____

The purpose of this disclosure is

___ Coordination of care
___ Requested by Individual Receiving Services, or guardian/parent
___ Other _____

1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3) The HCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

___ 90 days from date signed
___ 365 days from date signed
___ other date: _____

Approved by: _____ Date: _____

If signed by someone other than the Individual being served:

Print Name_____
Authority to sign: ___ Parent or Guardian
____ Appointed by Individual as HIPAA Personal Representative
____ Other _____

For staff use (complete the following steps and indicate by a check. Name of Staff Person _____)

___ Copy of signed authorization given to Individual / Parent / Guardian
___ Copy of records released given to Individual / Parent / Guardian (if requested)
___ Disclosure logged on Disclosure Log
___ Revocation received on _____ and acted upon.