THE CENTER FOR CHILD AND FAMILY ADVOCACY, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Date of Birth: _____ Last 4 Digits of SSN _____

I:_____ hereby authorize CCFA to release and/or obtain information for myself or the identified client with the following Entity or Individual: _____.

I hereby authorize these agencies to release and/or obtain the following information:

RELEASE	OBTAIN	
_____	_____	Diagnostic Assessment Summary
_____	_____	Information regarding progress, concerns, attendance, treatment, recommendations, diagnosis and compliance
_____	_____	Law Enforcement reports
_____	_____	Medical records
_____	_____	Monthly evaluations
_____	_____	Psychological evaluations
_____	_____	Psychiatric recommendations, including medications, diagnosis and treatment recommendations
_____	_____	School records
_____	_____	Therapy notes
_____	_____	Other _____
_____	_____	Other_____

Records and other information to be **excluded** from this authorization: _____
This consent expires on (**six months after date signed**): _____

_____ _____
Signature of Client/Guardian Date

I have discussed with the CCFA staff and understand the type of information that has been requested for release. Furthermore, we have discussed possible benefits and disadvantages of this information. I release The Center for Child and Family Advocacy, Inc. and the above-named entity/individual of any legal liability that may arise from the release and/or exchange of the indicated information.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. This authorization will remain in effect for 180 days. I hereby indicate that I am giving my authorization for the release of this information voluntarily, and that I understand that I am authorizing the release of protected health information. I have been informed that the provision of services for me is not contingent upon my decision concerning the release of information, except as specified below.

I understand that I may revoke this release of information at any time by written notification to The Center for Child and Family Advocacy, Inc., and that the revocation must be signed and dated by myself. I understand the exception to my revocation of this release would be to the extent that action has been taken prior to my notification. I understand that this authorization will expire 180 days from today's date or at an earlier date at my option (_____).

_____ _____
Signature of Client/Guardian Date

_____
Relationship

_____ _____
Signature of Witness Date

_____
Relationship

ATTENTION: The information disclosed to you from records is protected by Federal Confidentiality Rules (42 CRF, Part 2, Section 2.31 of PL-93-282). The Federal Rules prohibit you from making any further disclosures/copies of this information unless further disclosure is authorized by written consent of the person to whom it pertains or as otherwise permitted by (42 CRF, Part 2). A general authorization for the release of information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. This information is also protected by HB 244 of the Ohio Revised Code (5122).

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I understand that **by signing here I am revoking this authorization**, and that the revocation will be effective except to the extent that CCFA has already taken action in reliance upon my authorization. **I hereby revoke** the Authorization for Release of Information of the above information and **no further information will be released**.

_____	_____	
Signature of Client/Guardian (Same as above)	Date	Time
_____	_____	
Signature of Witness	Date	Time

Rev 2/2019
Rev 6/2015
Rev 9/2012
Rev 6/2012
Rev 5/2011
Rev 9/2009
Rev 7/2007
Rev 6/2007
4/2003