Seneca County Board of Developmental Disabilities (SCBDD)
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Individual Served_____
Date of Birth_____

I authorize SCBDD 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/IEH/IHP/IEP/ETR/504
- ☐ 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, except to the extent that action has been taken in reliance on it, by submitting a written request with the date and my signature and delivering it to: SSA Dept. of Seneca Co. Board of DD, 455 E. Market Street, Suite F, Tiffin, OH 44883.
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) A copy of this authorization shall have the same force and effect as the original.
4) **Check which of the following is applicable:**
   ☐ The Seneca County Board of Developmental Disabilities **does not require that I sign this authorization** in order to receive services.
   ☐ I understand that **if I refuse to sign this authorization, I may not be enrolled for services** in the DD Board because the DD Board cannot get information necessary to determine eligibility for DD Board services.

Check if applicable:
☐ This authorization is for release of protected health information for fundraising or levy purposes. The SCBDD may receive funds as a result of using my protected health information.

Expiration Date:
☐ One year from date signed ☐ Other date:_____

_____ _____
Date Signature

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 Office Use Only:
Staff person releasing information (signature) _____
(print name) _____
Date Information Released: _____