Ohio Department of Children and Youth

AUTHORIZATION TO RELEASE CONFIDENTIAL Ohio SACWIS INFORMATION

Ohio Kinship and Adoption Navigator Program

Section 1

Last Name	First Name	M.I.	Social Security Number	Ohio SACWIS ID #

Address	City	State	Zip Code

Section 2

I hereby authorize the following agency to disclose and allow access to confidential information about the above individual:

Disclosing Entity

Ohio Department of Children and Youth, Ohio SACWIS

Address	City	State	Zip Code
246 North High St.	Columbus	Ohio	43215

Receiving Entity

Ohio Kinship and Adoption Navigator Program, Kinnect

Address	City	State	Zip Code:
1427 E. 36th Street, Suite 4203F	Cleveland	Ohio	44114

Section 3

Reason for Disclosure:

To assist in the provision and coordination of services by the OhioKAN program.

Information to be disclosed

- Educational information, including school name, academic record, and special education information
- Medical information, including diagnoses (physical, mental health, substance use, and developmental), treatment providers, medications, immunizations, pregnancy, and insurance provider
- Employment information, including employer, income and expenses
- Military history, including branch, discharge data and discharge reason
- Delinquency history, including charges, adjudication, disposition, and court hearings

Section 4
By signing below, I understand that:
This Authorization will remain in effect until revoked or shall expire on date specified below or at the end of the service episode, whichever is earliest. I understand that I may revoke or cancel this Authorization at any time by submitting written revocation in the manner specified by OhioKAN, except information already released or disclosed before the Authorization is revoked. If this authorization has not been revoked it will expire on the date specified below or the completion of service episode. If no date is specified below, this Authorization will expire in one year.
Expiration Date: _____ or Service Episode End
I understand that my receipt of services and my eligibility for services is not conditioned on signing this Authorization unless the Authorization is necessary for determining eligibility for the program or enrollment in the program.
Substance use disorder records disclosed pursuant to this Authorization are protected by federal confidentiality rules (42 CFR part 2) and cannot be redisclosed without my written consent unless otherwise provided for in regulations. Any information disclosed pursuant to this Authorization other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
I have a right to inspect information that will be disclosed as per this Authorization.
I understand that this Authorization permits the disclosure of information related to HIV testing or the treatment of HIV and AIDS or AIDS related conditions, drug or alcohol use, and psychiatric conditions (excluding psychotherapy notes).

Signature of Individual or Representative	Printed Name	Date
Relationship to Individual ☐ Parent ☐ Legal Guardian/Custodian ☐ Power of Attorney ☐ Other		
Minor Signature if over 14 *(if able)*	Printed Name	Date