89 East Howe Road Tallmadge, Ohio 44278
330-634-8000 www.summitdd.org

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION

Name: _____

Date of Birth: _____ Local ID # _____ Phone: _____

Address: _____

I authorize the County of Summit Developmental Disabilities Board to (check one or both):

☐ **Release To** ☐ **Obtain From**

Facility/Individual: _____

Address: _____

I authorize the written or verbal release of the following information to/from SummitDD: Specific information to be obtained:

_____

The purpose of this authorized disclosure is (**state purpose in detail**):

_____

I understand that this authorization may be revoked or cancelled at any time (except to the extent that action has been taken in reliance on it) by notifying, in writing, to SummitDD's Privacy Officer, Summit DD Board, 89 E. Howe Road, Tallmadge, Ohio 44278.

UNLESS REVOKED, RELEASE WILL EXPIRE ON: _____

NOT VALID AFTER ONE YEAR FROM DATE OF SIGNATURE

☐ I understand that information in my record may include diagnoses and/or treatment for alcohol and/or drug abuse (**see next page for rule on re-disclosure of information on drug/alcohol diagnosis or treatment**); HIV test results; AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment; diagnoses and/or treatment relating to other communicable diseases.

☐ I understand that I have authorized the Summit DD Board to disclose my protected health information to persons who are not required by Federal or State law to keep the information confidential and that these persons who are receiving the records may disclose my protected health information to others without my consent or authorization.

☐ I understand that my records are protected by Federal and Ohio law governing confidentiality rules and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

☐ I am granting permission for SummitDD to release/receive third-party information.

IF THE INFORMATION DISCLOSED INCLUDES RECORDS OF DIAGNOSIS AND/OR TREATMENT OF DRUG OR ALCOHOL CONDITION:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other 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 patient.

A copy of this authorization shall have the same force and effect as the original.

Signature (if 18 years or older) or Parent (if under 18 years) or Legal Guardian/Custodian Date

If this Authorization is signed by the Custodian or Guardian, document showing authority to sign must be on file.

Signature of Witness Date

Rev 1/2020