BUTLER COUNTY
Board of
DEVELOPMENTAL
DISABILITIES

RELEASE OF INFORMATION AUTHORIZATION FORM

NOTE: All matters relating to an individual's records are considered privileged and confidential and are treated as such by the staff of the Butler County Board of Developmental Disabilities (BCBDD). Information regarding such matters cannot be released without the consent of the individual served or guardian.

Name of Individual: _____ **Date of Birth:** _____

I authorize BCBDD to ☐ release to ☐ obtain from the below: all medical records; also educational records and other information regarding my ability to perform tasks.

Agency/Facility/School Name: _____
Street Address: _____
City, State and Zip: _____

The following information:

yes	no		yes	no	
☐	☐	Current IP/IEP/IFSP for progress reports	☐	☐	Vocational Reports
☐	☐	Psychological/psychiatric reports	☐	☐	Social History
☐	☐	Pre-School/Early Intervention records	☐	☐	Legal documents
☐	☐	Treatment and Progress Notes	☐	☐	School Records
☐	☐	Medical reports/records	☐	☐	Assessment and Diagnosis (MFE)
☐	☐	FED and C/OEDI Evaluations	☐		Other:

The purpose of this disclosure is:

☐ **coordination of care for treatment/diagnosis of _____**
☐ **requested by the individual served/parent/custodial guardian/guardian**
☐ **other:** _____

Dates of information/ records requested: _____ to _____

Information released to BCBDD should be mailed to:

Butler County Board of Developmental Disabilities

_____

_____

Attn: _____

1) **I understand this information extends to all parts of the records indicated above, including psychiatric treatment, alcohol/drug abuse, HIV/AIDS related information, and communicable diseases, unless prohibited by law or otherwise indicated.**
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) **BCBDD does not condition that I sign this authorization for treatment, payment, eligibility, enrollment or receipt of services.**
4) **I understand that this authorization expires 1 year from the date signed or ; unless revoked in writing.**
5) **I understand that I may revoke this authorization at any time by submitting a written request and that BCBDD cannot be held responsible for any disclosures made prior to my written revocation or by another authorized recipient.**

_____ _____ _____ _____
Signature of Individual **Date** **Signature of Witness** **Date**

OR

_____ _____ _____
Signature of Guardian or Personal Representative of Individual **Date** **Relationship to Individual**

FOR BCBDD USE ONLY

Written revocation received on _____ and acted on by _____