Fairfield County Perinatal Services Council

Multi-System Consent for Release of Information

Client Name _____Date of Birth _____ Phone _____

I authorize the following agencies and/or organizations the right to exchange information regarding case history, psychological and education assessments, treatment, and progress updates in order to develop comprehensive service coordination goals that meet the needs of this client and/or family. Information released under this authorization may be subject to re-disclosure by the recipient of the information.

The agencies/organizations listed below have my permission to exchange/share information while assisting me with services through the Fairfield County Perinatal Services Council.

_____ Fairfield County ADAMH Board

_____ Fairfield County Board of Developmental Disabilities

_____ Fairfield County Department of Health

_____ Fairfield County Department of Job and Family Services (specify)
- __ Child Protective Services
- __ Child Support Enforcement
- __ Community Services

_____ Fairfield County Early Head Start and Head Start Programs

_____ Fairfield County Family, Adult and Children First Council

_____ Fairfield County Help Me Grow

_____ Fairfield Medical Center

_____ Integrated Services

_____ Mid-Ohio Psychological Services

_____ New Horizons Mental Health Services

_____ Pickerington Area Counseling Office

_____ The Recovery Center (Client must sign a separate specific release for exchange of information with The Recovery Center)

_____ School (specify):_____
_____

_____ Other Agency or Organization (specify):_____
_____
_____

I understand that I may revoke my consent to release information at any time. This consent form is valid for one year from the date the release is signed or as otherwise stated:

_____ / _____
(Client Signature) (Date)

— —

Sign below only if you wish to revoke your consent.

Revocation of consent: I hereby revoke the above consent for release of information.
Upon revocations of consent, further release of specified information shall cease immediately.

_____ / _____
(Client Signature) (Date)

Fairfield County Perinatal Services Council

Perinatal Cluster Referral (page 1 of 3)

Client Name _____ Referral Date _____

Email _____ Date of Birth _____

Address _____

City _____ Zip Code _____

Phone _____ Texting Permitted? _____

Race _____Gender _____ Primary Language _____

Referring Person/Agency _____

Possible Services Requested _____

Family Members:

- Mother _____ Address _____
  Home Phone _____Cell Phone _____
  Employer _____
- Father _____ Address _____
  Home Phone _____Cell Phone _____
  Employer _____
- Is there a Significant Other (i.e. boyfriend/girlfriend/relative) living in the home? _____
  Name _____ Relationship _____ Phone_____
  May information be shared with them? _____
- Child/Children (Please list all children)

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____

  Son/Daughter Name _____ Age _____ Date of Birth _____
  Currently resides with _____

  Is Mother currently pregnant? _____ Due Date _____
  Is Mother currently receiving OB/GYN Care? _____ Physician _____

Is client and family in a stable living environment? _____

If not, please explain housing needs _____

_____

Fairfield County Perinatal Services Council

Perinatal Cluster Referral (page 2 of 3)

Agency Involvement (check all that apply)

_____ Child Protective Services: Caseworker _____

_____ Court Program: Probation Officer _____
Charges _____

_____ Psychiatrist: Agency/Doctor _____

_____ Psychological Assessment: Agency _____

_____ The Recovery Center: Counselor _____
(Client must sign a separate, specific consent for exchange or release of information from The Recovery Center)

_____ Therapist: Agency _____

Hospitalizations _____

_____

Medications _____

_____

Insurance Information

_____ Private Insurance Provider _____

_____ Medicaid Managed Care Provider _____

Financial Statement

Annual gross income from Mother _____

Annual gross income from Father _____

Other income (i.e. child support, retirement, social security etc.) _____

_____

_____

Fairfield County Perinatal Services Council

Perinatal Cluster Referral (page 3 of 3)

Please write a brief summary of client needs and services requested from Fairfield County Perinatal Services Council

All referrals should be sent to:

Ann Probasco
Fairfield County Family, Adult and Children First Council
831 College Avenue
Lancaster Ohio 43130
740-652-7282
740-681-5540 (Fax)
ann.probasco@fairfieldcountyohio.gov

Referrals will be presented and reviewed at Fairfield County Perinatal Services Council meetings.