TRANSITION SERVICES

Greene County Board of Developmental Disabilities

245 North Valley Road • Xenia, OH 45385 • (937) 562-6500 •Fax (937) 562-6539 •
www.greenedd.org

Authorization for Use of Disclosure of Protected Health & Confidential Information

Re: ___________________________________ **DOB: _________________**
(Printed Name of Individual)

I hereby authorize the following person or organization to exchange/give/receive/share/disclose/re-disclose specific health information regarding service delivery for the purpose of securing, coordinating, and /or providing services for the above named person.

Greene County Board of Developmental Disabilities
(Name of Person/Organization)

To the following person or organization

Opportunities for Ohioans with Disabilities (Name of Person /Organization)____

Name of School____

List information being requested in detail:

Work Observations, Assessments, Interest Inventories

For the purpose of: Transition Planning

Unless earlier revoked, this authorization will expire on the 365th day of the signing or as otherwise specified __________ days.

(I may revoke this Authorization at any time by notifying the releasing organization/person in writing except to the extent that the releasing organization/person has acted on the authorization).

I understand that once this authorization is acted upon, the receiving party may be under no legal obligation to maintain the confidentiality of health information and could disclose it to another party.

I understand that the provision of health care services will not be affected if I do not sign this authorization form.

This release is not valid for information regarding drug abuse, alcohol abuse, and psychotherapy notes regarding sexually transmitted diseases.

A copy of this release has been offered to the individual, parent/guardian ____
(Signature)

Signature of Individual: ____ Date: ____________________________

Signature of Parent/Guardian: ____________________________________ Date: ___________________________