Ohio | Department of Health

Children with Medical Handicaps Program

P.O. Box 1603, Columbus, Ohio 43216-1603
(614) 466-1700 OR 1-800-755-4769

Release of Information and Consent

Child's/client's name	List all children in home currently involved with BCMH
Case number	
Birth date	
County of residence	

Release of Information and Consent

I authorize the Ohio Department of Health, Children with Medical Handicaps Program (herein after referred to as "CMH"), for services for the child or client (hereafter referred to as "client") to release confidential information concerning the client's medical condition and treatment, all financial information and third-party coverage to county and/or city health departments located in the city or county where the client lives or receives treatment and to health care and service providers, facilities, and third-party payors (and their agents and employees) for the purpose of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of all information concerning the client's medical conditions and treatment, including if applicable, the client's HIV testing or diagnosis of AIDS or AIDS-related conditions.

I hereby authorize my child's/my managing physician or service coordinator to submit this application to the Ohio Department of Health, Children With Medical Handicaps Program, for services for the child or client. I certify and attest that all the information given by me on this form and other CMH application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to CMH of all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom these claims, or amounts were paid.

The release authorization is effective from the date of my signature and will remain in effect until I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law. I have read this authorization to release information and fully understand its contents and acknowledge receipt of the CMH Health Insurance Portability and Accountability Act Privacy Notice.

When a child turns age 18, he/she must sign this form. If the 18-year-old is unable to sign, the parent or legal guardian may sign the form and provide a written explanation regarding the reason that the 18-year-old cannot sign, along with court documentation appointing parent as guardian.

_____ _____ _____
Parent/Legal Guardian/18 y/o Client Signature | Relationship to Client | Date

I,_____, Give permission to CMH to release information and/or discuss my
(Client's Name – Please Print)

case with _____ _____ _____
Name | Relationship to Client | Date