

**Williams County Service Coordination and Resource Management Team
Permission for Interagency Exchange of Information**

I hereby give permission for local public agencies participating in the Williams County Service Coordination and Resource Management Team to exchange information regarding the listed parties for whom I have legal authority to act.

I understand that designated representatives from the following agencies may attend the Williams County Service Coordination meetings, and/or Resource Management Team Meetings, and by their participation have access to private health information regarding the listed parties:

PRINTED NAME	DOB	SS#

I understand that all participating representatives are required to sign a Confidentiality of Protected Health Information Agreement. Also, I understand that Williams County Service Coordination/Resource Management Team and the Williams County Team may include some or all of the following:

Four County Family Center	Catholic Charities
Williams County Health Department	Woman and Family Services
Williams County Department of Job & Family Services	Center for Child and Family Advocacy
Williams County Board of MRDD	Recovery Services of Northwest Ohio
Williams County Family and Children First Council	Innovative Services
Northwest Ohio Educational Service Center	Lutheran Social Services
Williams County Elem., Middle and Senior High Schools	Independence Education Center
Williams County Juvenile Probation	Ability Center
Williams County Juvenile Courts/CASA representatives	Parent Advocacy Connection
Williams County Help Me Grow	Youth Placement Related Agencies
Ohio Department of Youth Services	Youth Workforce Investment Agencies
Adriel Foster Care	Four County ADAMhs Board
Williams County Auditor Office	Ohio Dept. of Mental Health and/or Drug Alcohol Addiction Services
Maumee Valley Guidance Center	Other _____

*Those in bold are mandatory for Resource Management/Clinical Team

Authorization

By signing this authorization form, I authorize the Williams County Service Coordination and Resource Management Team to exchange information in the manner described below. I understand that I am under no obligation to sign this authorization form. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the information described below.

I authorize the above listed organizations to exchange information for the sole purpose of the development of an interagency plan or to obtain funding for services. I understand that I may be involved in the process at the Williams County Service Coordination meetings. I understand that I have the right to 1) Revoke or restrict the authorization in writing at anytime, and that that revocation will be effective except to the extent that Williams County Service Coordination or the Resource Management Team has already taken certain actions in reliance on my authorization, 2) The right to inspect or copy the health information to be used or disclosed, 3) the right to receive a copy of this authorization.

I have had the opportunity to review this authorization form, and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes. This authorization will remain in effect for 180 days, unless I revoke it in writing prior to the 180-day term.

I have been offered Parent Advocacy Services: Accept Decline _____
(parent initials)--mandatory for Service Coordination Services.)

(Signature/Relationship) (Printed Name) (Witness) (Date)

I Hereby **revoke** this authorization effective as of: _____
(Date)

(Signature/Relationship) (Printed Name) (Witness) (Date)