Harold Lewis center

AUTHORIZATION TO OBTAIN INFORMATION

(To Include Use/Disclosure of Protected Health Information)

1280 Charles Lane
Marysville, Ohio 43040
(937) 654-6733
Fax # (937) 642-9909

I _____, **authorize the Harold Lewis Center and the following**
(Parent or Legal Guardian)

service providers and agencies to exchange/use/disclose specific health and educational

information concerning _____.
(Child's name and Date of Birth)

Please initial those providers you are giving consent to obtain information from:

_____	Nationwide Children's Hospital	_____	LEADS ,Head Start
_____	OSU Nisonger Center	_____	CCI (Consolidated Care, Inc.)
_____	Memorial Hospital of Union County	_____	Union County DJFS
_____	BCMH	_____	Community Action
_____	Help Me Grow	_____	WIC

_____ School District: _____
_____ Community Preschool: _____
_____ Childcare Provider: _____
_____ Private Therapist(s): _____
_____ Primary Physician: _____
_____ Specialists: _____
_____ _____
_____ Others Not Listed: _____

I understand that this authorization shall remain in effect for 1 year from the date of my signature below unless an earlier expiration date is specified in this space _____.

I understand that if the person or entity that receives the above information is not a provider or agency covered by federal privacy regulations, the information described above may be subject to redisclosure, and thus no longer protected by the federal privacy regulations.

I, the undersigned, hereby authorize the Harold Lewis Center to use and/or disclose information from the above service providers and/or agencies. This information will be used only for the purposes of providing services to enhance my family's capacity to meet the developmental needs of the child identified above.

_____ _____
Signature □ Parent □ Legal Guardian Date

_____ _____
Witness Signature Date