



8487 Ridge Road Cincinnati, Ohio 45236 Telephone: (513) 489-1616 Fax: (513) 766-3338

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(A photocopy of this authorization is to be accepted the same as the original.)

Authorization for release of information from **Adoption Connection** to other agency. Authorization for release of information from another provider or agency to **Adoption Connection**.

Client Name

Date of Birth

Social Security Number

Client Name

Date of Birth

Social Security Number

I, the undersigned, do hereby give permission to release the following information from my (or give relationship) _____ adoption record for the following purpose: _____.

THE FOLLOWING INFORMATION IS TO BE RELEASED BY ADOPTION CONNECTION TO:

Organization	Contact Person	Title
<input type="checkbox"/> Homestudy/Update	<input type="checkbox"/> Homestudy Education	
<input type="checkbox"/> Medical Statements	<input type="checkbox"/> BCI/FBI Results	Address
<input type="checkbox"/> Financial Statement	<input type="checkbox"/> CPR Certificates	City, Zip
<input type="checkbox"/> Fire Inspection Report	<input type="checkbox"/> Proof of Residency	
<input type="checkbox"/> Safety Audit	<input type="checkbox"/> References	(Phone #)
<input type="checkbox"/> Birthparent Assessment	<input type="checkbox"/> Home/Auto Insurance	(Fax#)
<input type="checkbox"/> Telephone Collaboration Concerning: _____		
<input type="checkbox"/> Other: _____		

THE FOLLOWING INFORMATION IS TO BE RELEASED TO ADOPTION CONNECTION BY:

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<input type="checkbox"/> Birthparent Assessment	<input type="checkbox"/> Home/Auto Insurance	(Fax#)
<input type="checkbox"/> Telephone Collaboration Concerning: _____		
<input type="checkbox"/> Other: _____		

I authorize the release and/or receipt of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions. For persons in treatment for substance abuse, even if those problems are not the primary reason for treatment, federal regulations regarding release of information according to Federal confidentiality rules (42 CFR part 2) or subsequent revisions shall be followed.

Adoption Connection may not condition or withhold services provided on whether or not you sign this Authorization.

THIS CONSENT WILL EXPIRE NINETY (90) DAYS AFTER THE DATE BELOW, OR SOONER BY CHOICE, IN WHICH CASE IT WILL EXPIRE ON _____. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION ANY TIME I CHOOSE PRIOR TO THIS DATE. (Note: you may not indicate that there is no expiration date.)

THIS INFORMATION MAY NOT BE RELEASED TO ANY OTHER PARTY WITHOUT MY CONSENT.

SIGNATURE OF CLIENT OR PARENT OF MINOR

DATE

SIGNATURE OF CLIENT OR PARENT OF MINOR

DATE

WITNESS

DATE