



Residential State Supplement Authorization for Release of Information



I, _____ [_____] , hereby authorize the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to release my Protected Health Information (PHI) and other personal, non-public information to the individuals or agencies listed below for the purpose of facilitating my enrollment in the Residential State Supplement (RSS) Program and to assist with my possible transition from an institution to an integrated community setting. I understand that PHI and other personal, non-public information includes, but may not be limited to, my social security number, date of birth, address, phone number, income type and/or amount, physical or behavioral health diagnoses, and previous or current treatment and services received.

- Ohio Department of Job and Family Services (ODJFS) and County Department of Job and Family Services
- Ohio Department of Medicaid (ODM)
- Ohio Department of Aging (ODA) and Area Agencies on Aging
- Ohio Department of Developmental Disabilities (DODD) and County Boards of Developmental Disabilities
- Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards
- Providers contracting with OhioMHAS, ODM, ODA, DODD or ADAMH/ADAS Boards
- Residential Facility Operator or Residential Care Facility Operator; **please enter name of facility and operator here:** _____
- Representative Payee (if applicable); **please enter name of individual or agency acting as payee for RSS benefits here:** _____
- Nursing Facility (if applicable); **please enter name of facility here:** _____

My refusal to sign this authorization will NOT exclude me from enrolling in the RSS program, but may impact the OhioMHAS' ability to act on my behalf in obtaining benefits and assisting with my transition to an integrated community setting. This authorization will remain effective for 365 days unless an earlier date or condition/event is specified here: _____. I understand I have the right to revoke this authorization in writing, at any time, and that the revocation will be effective except to the extent that OhioMHAS has already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to: *Community Transitions c/o OhioMHAS, 30 E. Broad Street, 36th Floor, Columbus, OH, 43215.*

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| Printed Name of Individual or Legal Guardian (if applicable) | Signature of Individual or Legal Guardian (if applicable) | Date Signed (mm/dd/yyyy) |
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If this authorization has been signed by a legal guardian on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____.

NOTE: This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 prohibit you from making any further disclosure of it without the specific and informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is NOT sufficient for this purpose.

Please return to Community Transitions via encrypted email to RSS@mha.ohio.gov or fax to 614-485-9747.