Department of Mental Health & Addiction Services

Residential State Supplement
Authorization for Release of Information

I, _____ [_____], hereby authorize the Ohio Department of Mental Health
(Individual's First & Last Name) *(Date of Birth)*
and Addiction Services (OhioMHAS) to release my Protected Health Information (PHI), Patient Identifying Information (PII), 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, confirming my residence is an eligible living arrangement, assisting with my possible transition from an institution to another setting, and helping obtain local resources and services. I understand that PHI, PII, and other personal, non-public information includes, but may not be limited to, my name, social security number, date of birth, Medicaid case number, address, phone number, income type and/or amount, physical and behavioral health diagnoses, and previous or current treatment and services received.

Name of Agency	*Name of Individual Contact*
Residential Facility or Residential Care Facility (**required** name here):	Facility Operator (**required** name here):
Representative/Protective Payee (if applicable; name of agency or individual here):	
Nursing Facility (if applicable; enter name of facility here):	Discharge Planner (if applicable; enter name here):
Ohio Department of Medicaid (ODM) and the Managed Care Plan in which I am enrolled	
Ohio Department of Job and Family Services (ODJFS) and County Department of Job and Family Services (no PII)	
Alcohol, Drug Addiction, and Mental Health (ADAMH) or Alcohol and Drug Addiction Services (ADAS) Boards	
Ohio Department of Aging (ODA), Area Agency/ies on Aging, State and Local Offices of the Long-Term Care Ombudsman	
Ohio Department of Developmental Disabilities (DODD) and/or County Boards of Developmental Disabilities	
Other (if applicable; enter name of individual or entity here):	

I understand that I may not be denied treatment, payment for services, or enrollment in a health plan, but may be denied eligibility for the Residential State Supplement Program if I refuse to sign this authorization. This authorization will remain effective while I am enrolled in the program unless another 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 Integration c/o OhioMHAS, 30 E. Broad Street, 36th Floor, Columbus, OH, 43215*.

Printed Name of Individual or Legal Guardian (if applicable)	Signature of Individual or Legal Guardian (if applicable)	Date Signed *(mm/dd/yyyy)*

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: _____.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure except as prohibited by state and federal law. ORC 5119.27, 5119.28, 5122.31, and/or 42 CFR Part 2 may prohibit recipient from making any further disclosure of it without my specific and informed authorization for release, or as otherwise permitted by law.