Logan County Department of Job & Family Services
Child Support Division (CSEA)

120 E. Sandusky Avenue, P.O. Box 517, Bellefontaine, Ohio 43311 (Former Logan County Library) Phone 937-599-7232 or Fax 937-599-3176

MEDICAL INFORMATION RELEASE AUTHORIZATION

I, _____, hereby authorize this medical institution, treating physician, counselor, therapist, or other medical profession to release to the Logan County Child Support Enforcement Agency (LCCSEA) all my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, etc, related to my recently reported inability to engage in gainful employment.

Healthcare Provider	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further authorize you to provide to and discuss with the LCCSEA and its representatives any confidential information with respect to my medical condition or treatment, either formally or informally.

Patient's Name:_____ DOB:_____

Purpose of Disclosure: To obtain information to verify the Patient's statements to our Agency regarding inability to be gainfully employed.

I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above named healthcare provider(s) or its physicians, employees or agents before the healthcare providers(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s) and provide a copy to the LCCSEA.

I understand that I am not required to sign the Authorization. However, I understand that if I do not sign this Authorization, the LCCSEA cannot assist me in obtaining medical verification and that I must supply medical records and documents on my own that demonstrate that I am totally disabled to engage in all substantial gainful employment.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above named healthcare provider(s) or its physicians', employees', or agents' ability to use or disclose my information for treatment, payment or healthcare operations, or as otherwise permitted by law.

I further understand and acknowledge that I am responsible for all costs associated with the provisions of the information described herein to the LCCSEA.

Patient's signature: _____

Date of signature: _____

This Authorization will expire two years after the date of signature above. A photostatic copy of this Authorization is to be considered as valid as the original.