Consent for Release of Information
In The Event Of Serious Illness, Incapacitation or Death

Our program will not tell anyone the information you have provided to us unless you specifically give us permission (unless we are required under law to do so). Domestic violence can result in serious injury, or death, or you may experience a severe illness or condition while being served by our program. You could be too ill to sign a release or tell us what information you want shared. This document is to tell us what you want us to do in those circumstances. In this document, your initials and signature tell us who we can share information with, what information can be shared, and expresses your agreement that the program will be held harmless for the release of any information you have authorized here.

I understand that signing this release is voluntary and will not affect my ability to receive services. I understand that I do not have to sign it.

Throughout this document, the program that may release information is:

What Information Can Be Shared

In the event that I become seriously ill and cannot give consent for release of information or I am deceased, I give permission for the program to release information about my children and me. The specific information I consent to be released includes:

_____ **My condition**

_____ **My location**

_____ **Any known information about my wishes, including any Power of Attorney documents I have signed.**

_____ **Other –** List other information you give permission to be shared (for example, location of your vehicle and keys, contacting your or your child's school, the needs of pets to be cared for, passwords to financial accounts, where your mail should be forwarded, etc.):

Who Can Receive My Information - (Please initial each box if you are giving consent)

_____ **Police and prosecutors**

Please be aware that information released to the police or prosecutor is not confidential. Members of the public, including news reporters, may see this information.

_____ If I am incapacitated by my abuser, or deceased, I also consent to the program to release information I have provided about the abuser and history of abuse to police or prosecutors.

_____ **Courts -** Please notify any Courts where I have any action(s) pending.

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Family member(s) and/or friend(s) or other person(s)**

(1) Name(s): _____

Address: _____

Phone: _____ E-mail: _____

(2) Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Landlord**

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Employer**

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Caseworker at Children's Services (Ohio Department of Jobs and Family Services)**

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Parole or probation officers**

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

_____ **Medical Facility where I may be treated**

_____ The program may also tell any medical facility where I am being treated that I am a survivor of domestic violence, the name(s) of my abuser(s), with a request that this person not be permitted to enter any area where I am being treated or notified that I am present in the facility.

_____ **Other – Please notify this person/organization**:

Name(s): _____

Address: _____

Phone: _____ E-mail: _____

I do not intend for the limited release of information described above to operate as a general release. It is only for the circumstances of severe debilitating illness, incapacity or if I am deceased. I understand I can change my mind and tell the program in writing or verbally at any time that I no longer agree to my information being released.

Comments:

_____ _____

Signature Date

_____

Printed Name

Program Representative

_____ _____

Signature Date

_____

Printed Name and Title