



**Permission to Disclose Personal Health Information to:  
Information System (GOSH) and Ohio Behavioral Health Information System (OBHIS)**

In order for your services to be paid for--in part or in full--by the Community Mental Health, or Alcohol and Drug Addiction Services Boards, and/or Job and Family Services, and/or Medicaid it is necessary to enroll you (the client) in the GOSH and OBHIS shared database systems.

The information entered into the database is used to:

- Enroll the client in the Great Office Solution Helper (GOSH)
- Enroll the client in the Ohio Behavioral Health Information System (OBHIS)
- To determine eligibility for publicly funded services.
- To pay claims for services received.
- To report information required by the CMH/ADAMH Board and/or OhioMHAS regarding characteristics of individual seeking services and the types of services provided. The Boards and/or OMHAS use the information in aggregate form for service planning and evaluation purposes.
- To report information required by the CMH/ADAMH Board and/or the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to measure effectiveness of services and evaluate treatment outcomes in my case and other similar cases.
- To report information to the CMH/ADAMH Board and OhioMHAS, as required by Ohio law, about reportable incidents that may occur while I am receiving services.

Child Focus may disclose information necessary to be paid for mental health services even if I do not authorize disclosure.

Treatment cannot be conditioned upon my signing this authorization.

I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment with Child Focus ends.

I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that Child Focus cannot control the use of this information once it has been disclosed.

By signing below, I am indicating that I understand all of the above. I authorize Child Focus to disclose information necessary to the Great Office Solution Helper and Ohio Behavioral Health Information System.

Client: \_\_\_\_\_ Client D.O.B.: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Today's Date: \_\_\_\_\_