ASHTABULA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Community Support Services
500 West Main Street
Geneva, OH 44041
(440) 466-7110 * Fax: (440) 466-7047

CONSENT FOR COMMUNITY SUPPORT SERVICES

My signature on this document indicates my consent to receive Community Support Services (Service and Support Administration) from the Ashtabula County Board of DD.

Individual/Student Name_____

Date of Birth_____ SSN_____

Address_____

Signature of Individual/Student_____ Date_____

Signature of Parent/Guardian_____ Date_____

Address, if different from above_____

This *CONSENT* form was explained to the above named individual on_____
(date)

by_____, of_____

Signature of Witness_____ Date_____

Address_____

THIS CONSENT IS VALID FOR ONE (1) YEAR FROM DATE OF INDIVIDUAL/GUARDIAN SIGNATURE.
THIS CONSENT MAY BE REVOKED AT THE REQUEST OF THE INDIVIDUAL/GUARDIAN.
ALL DATA WILL BE MAINTAINED AS CONFIDENTIAL.

THE ASHTABULA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES RECORD RETENTION POLICY IS THAT THE COUNTY BOARD CAN BEGIN DESTROYING RECORDS AFTER THREE (3) YEARS. IF YOU WOULD LIKE ANY OF THE RECORDS PLEASE NOTIFY THE COMMUNITY SUPPORT SERVICES OFFICE.

I have been informed that the Ashtabula County Board of DD adheres to Health Insurance Portability and Accounting Act of 1996 (HIPAA) when processing Personal Health Information.

Signature_____