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| **Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_ |
| **RELEASE OF INFORMATION** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This information is to be released and/or exchanged between and among the identified agencies or persons solely for the purposes of obtaining accurate and complete history for agency records, and/or, for the process of consideration, treatment and follow-up related to participation in agency programs, including but not limited to clinical trials research, day treatment, and/or residential care. Any other use is strictly prohibited under federal law. I understand that the information may/will include treatment for mental and/or physical illness, human immunodeficiency syndrome (HIV) or tests for HIV or AIDS.  **I Hereby Authorize To Release and/or Obtain Information From:**   |  | | --- | | Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **Section 1**  (Patient signature captured for Section 1 at the bottom of this Release of Information)  **I agree that Southern Iowa Mental Health Center may release and/or obtain the following information from the patient record:**    Discharge Summary  Psychological Evaluation  Treatment Plan  History and Physical  Admission Note  Consultations Lab Reports (ECG, Blood work, MRI/CT)  Progress Notes  Physician Orders Social/Occupational Hx  Medication Administration Record  Psychological Testing/Reports  Communications  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Amount of Information to be Disclosed and/or Obtained:**  Information Covering the Previous 3 Months  Information Covering the Most Recent Admission/Visit  Information Covering the Previous Year  All Information  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Purpose: I understand that this information will be used for the following** (Check all that apply):  Evaluation / Treatment  Legal Purposes  Insurance / Billing Purposes  Care Coordination  Referral for New Service  Monitoring of Services  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Section 2**  (Patient signature captured for Section 2 at the bottom of this Release of Information)  **Specific authorization for release of information protected by State and Federal law.**  I specifically authorize the release of date and information relating to (check appropriate line):  1. Alcohol & Drug Abuse  2. Mental Health  3. HIV Related Information  4. Genetic Testing (G.I.N.A.)  5. Developmental Disabilities  **NOTE:** I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (Title 42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV/Acquired Immune Deficiency Syndrome (AIDS) test results or diagnosis (ORC3701.24.3)  I hereby state that I have read and fully understand the above statements as they apply to me and do herein expressly consent to disclosure for the purpose or need and the extent or nature as stated above. I further understand that I may revoke this consent at any time in writing to the Agency Privacy Officer, except where disclosure has already been made, or upon the occurrence of the event: the purpose for which the disclosure is hereby authorized. I understand that the information you release or obtain will be used as appropriate and necessary for my treatment and does not constitute breach of my rights to confidentiality.  **NOTE:** This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Title 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.  **NOTE**: This authorization is effective for one year from the date signed or you may choose a specific date to end this authorization, whichever comes sooner.  Expiration date chosen if sooner than one year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  A printed, photocopy, or exact reproduction of this authorization, as duly executed, shall have the same force and effect as the original.  Relationship of Patient Representative who is signing this Release of Information:  Self  Guardian  Parent/Guardian  Was a copy of Release of Information given to the client?  Yes  No  **Parent/Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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