AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION

|  |  |
| --- | --- |
| AGENCY NAME: |  |
| Agency address: |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| CLIENT NAME: |  | DATE OF BIRTH: |  |

Reason for request to release, obtain or exchange information: Care Coordination

I VOLUNTARILY AUTHORIZE (*insert MCAH agency name*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_staff to release, obtain, and exchange information with the following agencies (specific name/agency/clinic must be listed to share substance abuse information):

|  |  |  |
| --- | --- | --- |
| NAME/AGENCY | Clinic Name/ADDRESS | PHONE |
|  | | |
|  |  |  |
|  | | |
| I authorize the release and exchange of the following information: | | |
| |  |  | | --- | --- | | □ Medical Records | □Social and Family History | | □Screening Results | □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

|  |  |  |
| --- | --- | --- |
| Specific Authorization for Release of Information Protected by State or Federal Law:  I understand that information to be released may include material that is protected by federal and/ or state law applicable to substance abuse, mental health, and/ or HIV/AIDS – related information. **I specifically authorize, by initialing below, the release of the following types of records:** | | |
| Mental Health\*: | Substance Abuse\*\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | HIV/AIDS: |
|  | | |
| \*Only client 18 years of age or emancipated teenager, or legal representative can authorize release of mental health information. | | |
| \*\*Only client, regardless of age, can authorize release of substance abuse information. | | |

I UNDERSTAND that the AUTHORIZATION TO RELEASE, OBTAIN, AND EXCHANGE INFORMATION form is limited to the agencies, groups, or persons named; and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. However, any information already released may be used as stated on this authorization form. I understand the information is needed to plan services or to determine eligibility for services. This authorization is effective for no longer than one year from the date of signature or for \_\_\_\_\_\_ months. This authorization is not automatically renewable. It expires from the date of signature. I understand that if the person or entity that receives the information requested is not covered by federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be re-disclosed and will no longer be protected by the regulations. I have read this release or it has been read to me, and I understand its content. Photocopies of this release will be as valid as the original.

I certify that any person(s) who furnish such information concerning me shall not be held accountable for providing this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result. I further release the Iowa Department of Health and Human Services from any and all liability which may be incurred as a result of collecting or disclosing such information.

**Disclosure and Re-disclosure**: Iowa and federal law provides that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement. “This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly or indirectly, by reference to publicly available information or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the person of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to investigate of prosecute with regard to a crime any patient with a substance abuse disorder, except as provided at §§ 2.12(c)(5) and 2.65. See also Iowa Code Chapters 141A and 228, and other applicable laws.

This form does not authorize re-disclosure of medical information beyond the limits of the consent.

Signature of Client or Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_