State Opioid Response in Iowa - Release of Information

I, _____ authorize _____
(Client) (Service Provider)

to exchange information verbally and/or in writing with:

_____

The nature and amount of the information shared will be as limited as possible, but may include:

☐ personal identifying information
☐ participation and status in SOR funded services
☐ medical evaluation results
☐ drug test results
☐ other (specify): _____

This consent is specific to my participation in the State Opioid Response in Iowa Project and will be used for care coordination, to monitor and evaluate services, and to submit claims to the Iowa Department of Public Health.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. Federal rules prohibit 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 in writing. 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 criminally investigate or prosecute any alcohol or drug abuse patient.

I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically on the date on which all billing and reporting requirements related to my participation in Access to Recovery have been completely processed.

I understand that, generally, a program may not condition my services on whether I sign a release of information, however, in the special circumstances of the voluntary SOR project, I understand that I cannot participate if I do not sign a release of information.

Client Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____
(if applicable)

Provider / Witness Signature _____ Date: _____