IOWA | Health and Human Services

# Authorization to Disclose Personal Health Information Release Form

Use this form to tell Iowa HHS who can access your personal health information. Whether you choose to share your personal health information or not has no impact on your enrollment, eligibility for benefits, or the amount Medical Assistance pays for your health services.

**Information About the Medical Assistance Recipient or Applicant.** Use this form if you want Iowa HHS to give your personal health information to someone other than you.

| | |
|---|---|
| Client Name: | DOB: |
| Address: | State ID: |
| Parent/Guardian (if applicable): | |

**Select the information you want Iowa HHS to share.** Check only one box.

| | | |
|---|---|---|
| ☐ Information related to eligibility for medical assistance only | | |
| ☐ Mental Health information | ☐ HIV/AIDS Information | ☐ Substance use information |
| ☐ Other: | | |

**How long can Iowa HHS use this authorization to share your information?** Check only one box.

| |
|---|
| ☐ One year from the date of signature |
| ☐ When an eligibility decision has been made |

**Enter the name of each person or organization that can get your personal health information from Iowa HHS.**

| | |
|---|---|
| Full Name: | Phone Number: |
| Address: | |
| ☐ Check this box if you would like this person or organization to receive a copy of any request for information and notice for an application submitted within 120 days of the date this release is signed. | |

IOWA | Health and Human Services

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date or event specified above. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the person or organization authorized to receive this information is not a health plan or health care provider, the released information may not longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact the Privacy Officer at 1-800-803-6591. I have read this form, or it has been read and explained to me, and I understand its content.

**By signing this form, I authorize Iowa HHS to share my personal health information listed above to the person(s) or organization(s) named on this form.** I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

| | |
|---|---|
| Name (Please print): | |
| Signature: | Date: |
| ☐ Check here if you are signing as a personal representative and complete the form below. Be sure to attach the appropriate documentation (like a Power of Attorney) if applicable. | |

**Personal Representative's Information**

| | |
|---|---|
| Name of Parent or Legal Guardian (Please print ): | |
| Address: | |
| Phone Number: | |
| **Relationship to the person (please check one)** | |
| ☐ Parent | ☐ Power of Attorney |
| ☐ Guardian | ☐ Other: |
| Signature of Parent or Legal Guardian: | Date: |

**Send the completed, signed authorization form to:**

Davenport Service Area
Imaging Center 3
PO Box 8022
Davenport, IA, 52808-0000
Fax: 515-564-4016
Email: facilities@dhs.state.ia.us

IOWA | Health and Human Services

**Notice to Recipients of Mental Health Information**
In accordance with “Disclosure of Mental Health and Psychological Information” (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject’s legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of Substance Abuse Information**
This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit unauthorized use or disclosure of these records without specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of HIV-Related Testing Information**
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity**
It is the policy of the Iowa HHS to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status. If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: HHS, Bureau of Human Resources, 321 E. 12th St., Des Moines, IA 50319 or via email inclusion@hhs.iowa.gov