IOWA Health and Human Services

# Authorization to Obtain or Release Health Care Information

| Client Name: | ID#: | SSN#: |
|---|---|---|
| Date of Birth: | Parent/Guardian: | |

**I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive.**

| Name or agency to release and receive information: | |
|---|---|
| Address: | |
| City/State/Zip: | |
| Phone: | Fax: |

**With the following individual or agency:**

| Name or agency to receive and release information: | |
|---|---|
| Address: | |
| City/State/Zip: | |
| Phone: | Fax: |

***The information released or shared may include*:**

- ☐ Face sheet
- ☐ Discharge summary
- ☐ Lab results
- ☐ X-ray/imaging reports
- ☐ History & physical exam
- ☐ School records
- ☐ Receiving phone calls
- ☐ Other (please specify):
- ☐ Admission status
- ☐ Family data photos
- ☐ Treatment and aftercare plans
- ☐ Team notes
- ☐ Initial assessment
- ☐ Court documents
- ☐ Consultation reports from (doctor/specialty name):
- ☐ Psychological reports
- ☐ Social history
- ☐ Diagnosis/allergies
- ☐ Medication history
- ☐ Immunization record
- ☐ Evaluation & recommendations

| **Other (note exceptions or limits to this release):** |
|---|
| **This information is being used ONLY for (state purpose):** |

| **Specific Authorization for Release** | **Type of Information** | **Authorizing Initials** |
|---|---|---|
| I authorize the release of the information listed at the right, which requires specific consent under federal law: | Mental health evaluation/treatment* | |
| | AIDS/HIV-related | |
| | Substance abuse** | |

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

specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. 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 persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no 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 (name) the Privacy Officer at (phone) 1-800-803-6591. I have read this form, or it has been read and explained to me, and I understand its content.

| Authorizing signature: | Date: | Expiration date: |
|---|---|---|
| Relationship to client: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other (Specify): | | |
| ☐ Not Required | Witness signature: | |
| ☐ Required | Witness signature: | |

A photocopy of this signed authorization shall have the same force and effect as this original.

**Record Of Disclosures**
(Required for mental health information)

| | Date | Name of Recipient | Contents Disclosed | Sent By |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

**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 any further disclosure without the 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 Department of Health and Human Services (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, gender identity, 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:

Iowa Department of Health and Human Services, Lucas Building, Bureau of Human Resources, 321 East 12th St., Des Moines, IA 50319 or via email inclusion@hhs.iowa.gov