IOWA Health and Human Services

Authorization to Obtain or Release Health Care Information

Client Name:	ID#:
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:

☐ Health information ☐ Demographic information ☐ Billing records
☐ Psychotherapy notes ☐ Substance use disorder counseling notes
☐ Other (please specify):

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 use disorder**	

I specifically authorize the use of my substance use disorder treatment records for the following proceeding(s):

☐ Civil ☐ Administrative ☐ Criminal ☐ Legislative

I understand that if HIPAA covered entities and business associates receive these records for treatment, payment, and health care operations purposes, the records may be redisclosed in accordance with HIPAA, except for uses or disclosures for civil, criminal, administrative, or legislative proceedings against me.

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 one year 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 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.

Client signature:	Date:	Expiration date:
Other authorized person signature:	Date:	Expiration date:
Name of person signing, if other than client:		
Relationship to client: ☐ Self ☐ Personal representative ☐ Other authority of person signing (e.g., 42 CFR §§ 2.14, 2.15):		

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.

** Iowa Code § 125.33A(4) grants minors or their parent/guardian the legal authority to authorize disclosure of the minor's substance use disorder treatment participation.

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 Use Disorder Treatment Information

This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

(i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.

(ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or

(iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E.

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

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)

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, 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 compliancehotline@hhs.iowa.gov.