CONSENT TO RELEASE INFORMATION

Northwest Iowa Mental Health Center (Seasons Center)
201 East 11th Street, Spencer, Iowa 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Client's Legal Name: _____ DOB: _____ Medicaid # _____

By signing this form, I am allowing Seasons Center to ☐ release or ☐ obtain written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

☐ Psychiatric Evaluation
☐ Med/Progress Notes
☐ Psychological Testing/Assessments
☐ Educational/Vocational Records
☐ Service Plan/ICP/Treatment Plan
☐ Laboratory Results
☐ Billing Information
☐ Appointment Dates/Info
☐ Discharge Summary
☐ Social History
☐ Medical Records
☐ Annual Review
☐ Initial Assessments
☐ Progress Summary
☐ All of the above
☐ Other: (Please Specify) _____

Please indicate the reason for release:

☑ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Seasons Center 201 E 11th Street, Spencer, IA 51301. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Seasons Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Seasons may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Seasons may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse _____ Mental Health _____ HIV-related Information _____ Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here, whichever is earlier: _____

_____ _____
Client/Legal Guardian Signature Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information. Only clients, regardless of age, can authorize release of substance abuse information.

Office Use Only:

Please send records: ☐ Date records/request was sent and by whom: _____
Please request records: ☐ Description of records sent: _____