CONSENT TO RELEASE OF INFORMATION Northwest
Iowa Mental Health Center (Seasons Center)
201 E 11th St, Spencer, IA 51301
Phone: (800) 242-5101 Fax: (712) 262-3826

Patient's Legal Name _____ Birth Date _____ 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 patient with the following individual or agency:

_____
Name of Person and/or Institution

_____ (___) _____ (____) _____
Address City State Zip Phone # Fax #

Check the information to be disclosed:

☐ Psychiatric Evaluation	☐ Laboratory Results	☐ Medical Records
☐ Med/Progress Notes	☐ Billing Info	☐ Annual Review
☐ Psychological Testing/Assessments	☐ Appointment Dates/Info	☐ Initial Assessments
☐ Educational/Vocational Records	☐ Discharge Summary	☐ Progress Summary
☐ Service Plan/ICP/Treatment Plan	☐ Social History	☐ 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. If I choose to cancel this consent at a later date, I must send written notification to: Medical Records, Seasons Center, 201 E 11th St., Spencer, IA 51301. If this consent is cancelled, 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. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

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

This agreement will expire one year from the date of signature, or on date specified: _____

_____ _____
Patient Signature Date

_____ _____ _____
Legal Guardian Signature Date Relationship

_____ _____
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: _____