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 and/or ☐ obtain written and oral information for the ***past two (2) years*** from the date of this release by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

Name of Person (or Class of Person) _____ Name of Institution (if applicable) _____ Relationship to Client _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____ Case/Investigation Number _____

Check the information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Comprehensive Intake (including Social History)
- ☐ Initial Assessments
- ☐ Service Plan/ICP/Treatment Plan
- ☐ Med/Progress Notes
- ☐ Annual Review
- ☐ Progress Summary
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Appointment Dates/Info
- ☐ Laboratory Results
- ☐ Psychological Testing/Assessments
- ☐ Educational/Vocational Records
- ☐ Other (please specify): _____

Please indicate the purpose/reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Insurance ☐ Transferring Care ☐ *Legal* *if selected, **NO** other items in this section may be selected*

☐ Other (please specify): _____

This authorization is voluntary. I understand that I have the right not to sign this consent form, and 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 not to sign, I understand there will be no consequences to service provision; however, it may impact payment for services and personal obligations for services. 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 42 CFR Part 2, HIPAA, and other federal or state 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 (HIPAA, 42 CFR § 2, and 45 CFR § 164) and the code of Iowa Chapter 228. **42 CFR Part 2 prohibits unauthorized use or disclosure of these records.** Part 2 redisclosure is prohibited, unless further disclosure is expressly permitted with the client's written consent, except as permitted by 42 CFR Part 2, HIPAA, and applicable state laws. 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.

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, 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, and c) I understand that I may be billed for services, otherwise covered by insurance, if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law.

INFORMATION TO NOT RELEASE

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 type of information you do *NOT* want released. Leave blank if no restrictions.

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

I have been offered a copy of this form, and it has been explained to me in a language I understand.

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 Representative Signature _____ Relationship to Client _____ Date _____

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.