SOUTHWEST IOWA MENTAL HEALTH CENTER

Authorization to Release and/or Receive Protected Health Information

Patient Name___________________________________ D.O.B.: ___________ Medical Record#______________

Address: ____Phone# ___________________________

Notice to Recipient of Information: This information has been disclosed to you from records whose confidentiality may be protected by federal and state law. If the records are so protected, Federal Regulations (42 CFR Part 2) and Chapter 228 Code of Iowa prohibits you from making any further disclosure of it without written consent of the person to who it pertains, or as otherwise permitted by such regulations. An unauthorized disclosure of mental health, substance abuse, and/or AIDS/HIV related information is unlawful and may result in civil damages and/or criminal penalties. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I hereby authorize Southwest Iowa Mental Health Center to use and/or disclose my health information as follows:

Disclose To: ____
Recipient Name Address Phone Number

Obtain From: ____
Source Name Address Phone Number

Purpose(s) of Disclosure: ____

☐ Check this box if disclosure is at the request of the individual

INFORMATION TO BE DISCLOSED:

☐ History and physical examination/Intake
☐ Progress notes/Clinical notes
☐ Lab reports
☐ X-ray reports
☐ Consultation report
☐ Emergency room record
☐ Discharge Report
☐ Aftercare Plan
☐ Financial record
☐ Complete record
☐ Acknowledgement of referral
☐ Treatment Plan/Diagnosis
☐ Psychological Testing Results
☐ Psychiatric Evaluation
☐ Prior Psychiatric History
☐ Program Planning & Coordination
☐ Other: ____

☐ OASIS DATA: I authorize Southwest Iowa Mental Health Center to release to the Centers for Medicare and Medicaid Services, or its agents, any information contained or included in the Outcome and Assessment Information (OASIS). I permit a copy of the authorization to be used in place of the original.

I SPECIFICALLY AUTHORIZED THE RELEASE OF INFORMATION RELATING TO:

Substance Abuse (including alcohol/drug abuse)
Mental Health
HIV/AIDS related information (including test results)

____
Signature of Patient or Legal Guardian **Date**

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED: ____
(State time period or "all"

I understand and acknowledge that:

1.My refusal to sign this authorization will not affect my ability to obtain treatment at Southwest Iowa Mental Health Center.
2.Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
3.This authorization is effective for _____________ months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to Southwest Iowa Mental Health Center. My revocation will not be effective to the extent action has alaready been taken in reliance on my authorization.
4.I have read (or had read to me) and received a copy of this document.
5. I understand the content and nature of the material I am releasing.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect of the original.

____ ________________________________
Signature of Patient or Patient's personal representative Date

____ ________________________________
Relationship to Patient if signed by personal representative Witness

____ ________________________________
Request Completed by Date

1/1/2018