

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 125, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and with Polk County Health Services (a list of the current affiliated case management entities and other providers is available upon request), with the exception of the following Iowa counties, Regions or other entities: _____.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Table with 2 columns: Information to be disclosed includes; For the following purposes:
Information to be disclosed includes: Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance described in Iowa Code § 252.25.
For the following purposes: Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations and abiding by state and federal reporting requirements.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release and sharing of information relating to: (check and sign any that apply)

- Checkboxes for: HIV/AIDS Related Testing Information, Mental Health Information (NOTE: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes...), Chemical Dependency (Drug/Alcohol) Treatment Information. Includes signature lines for each.

Concerning the care of the above client from (select one):

- Any and all dates; or
Dates ___/___/___ to ___/___/___.

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:

- ___/___/___ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the client, please indicate relationship:

- parent or guardian of minor client
guardian or conservator of a client (if and to the extent authorized under State law)
personal representative of deceased client
other (specify) _____

REVOCACTION SECTION

I hereby revoke this Authorization.

Signed: _____ Date: _____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with 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. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of Substance Abuse Treatment Information: This information may have been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2), and Iowa Code Chapter 125. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code § 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

<u>Iowa Counties:</u>	Floyd	Monroe	<u>Iowa Mental Health and Disability Services Regions:</u>
Adair	Franklin	Montgomery	Central Iowa Community Services
Adams	Fremont	Muscatine	County Rural Offices of Social Services
Allamakee	Greene	O'Brien	County Social Services
Appanoose	Grundy	Osceola	Eastern Iowa MHDS
Audubon	Guthrie	Page	Heart of Iowa
Benton	Hamilton	Palo Alto	MHDS of the East Central Region
Black Hawk	Hancock	Plymouth	North West Iowa Care Connection
Boone	Hardin	Pocahontas	Polk County Health Services
Bremer	Harrison	Polk	Rolling Hills Community Services
Buchanan	Henry	Pottawattamie	Sioux Rivers MHDS
Buena Vista	Howard	Poweshiek	South Central Behavioral Health
Butler	Humboldt	Ringgold	Southeast Iowa Link
Calhoun	Ida	Sac	Southern Hills Regional Mental Health
Carroll	Iowa	Scott	Southwest Iowa MHDS
Cass	Jackson	Shelby	
Cedar	Jasper	Sioux	
Cerro Gordo	Jefferson	Story	
Cherokee	Johnson	Tama	
Chickasaw	Jones	Taylor	
Clarke	Keokuk	Union	
Clay	Kossuth	Van Buren	
Clayton	Lee	Wapello	
Clinton	Linn	Warren	
Crawford	Louisa	Washington	
Dallas	Lucas	Wayne	
Davis	Lyon	Webster	
Decatur	Madison	Winnebago	
Delaware	Mahaska	Winneshiek	
Des Moines	Marion	Woodbury	
Dickinson	Marshall	Worth	
Dubuque	Mills	Wright	
Emmet	Mitchell		
Fayette	Monona		