

Interagency Release Form

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF MEDICAL, MENTAL HEALTH, SUBSTANCE ABUSE, AND/OR CORRECTIONS INFORMATION

Applicant/Participant _____ Birthdate _____

I, the undersigned, authorize each of the agencies **initialed** below whose purpose is to coordinate the services and treatment of participating clients/patients with involvement in mental health, substance abuse, and corrections conditions:

- _____ Heartland Family Services, 515 E. Broadway, Council Bluffs, IA 51503
- _____ Jennie Edmundson Hospital, 933 E. Pierce St, Council Bluffs, IA 51503
- _____ Mercy/Alegent/CHI, 800 Mercy Dr., Council Bluffs, IA 51503
- _____ Alegent Health Psychiatric Associates, 801 Harmony St, Suite 302, Council Bluffs, IA 51503
- _____ Pottawattamie County Community Services, 515 5th Ave, Suite 113, Council Bluffs, IA 51503
- _____ Southwest Iowa MHDS Region, 515 5th Ave, Suite 113, Council Bluffs, IA 51503
- _____ Pottawattamie County Sheriff's Office, 1400 Big Lake Rd., Council Bluffs, IA 51501
- _____ Pottawattamie County Jail, 1400 Big Lake Rd, Council Bluffs, IA 51501
- _____ Council Bluffs Police Dept., 227 S. 6th St, Council Bluffs, IA 51501
- _____ Department of Corrections, Adult Probation, 801 S. 10th St, Council Bluffs, IA 51501
- _____ PDO or attorney of record; County Attorney; and other members of MHC team;
- _____ Mental Health and Substance Abuse Network, 515 5th Ave., Council Bluffs, IA 51503
- _____ Community Mental Health Center, 4102 Woolworth Ave, Omaha NE 68105
- _____ Lasting Hope Recovery Center, 415 S.25th Omaha NE 68131
- _____ Collaborative Support Team, 515 5th Ave, Suite 113, Council Bluffs, IA 51503
- _____ Other: _____ (family member and/or significant other must include address)

To disclose verbally and/or to release in writing to any and all of the participating agencies initialed above, the following information pertaining to the evaluation and/or treatment of the above-named client/patient:

- | | |
|---|--|
| _____ Attendance and Compliance | _____ Emergency Room Report |
| _____ Discharge Summary | _____ Pathology Report |
| _____ History and Physical | _____ Consultations |
| _____ Medical/Health | _____ Educational records |
| _____ Lab, X-Ray, EKG | _____ Other information as needed (specify) |
| _____ Progress Notes | _____ |
| _____ Diagnosis & Assessment
(for both mental/substance) | _____ On-going progress communication |
| _____ Insurance coverage/funding
Sources | _____ Confidential Iowa court files, including Juvenile,
Guardianship, Domestic Abuse and Emergency
Mental Health Committals under code 229. |

This information is to be used for the coordination of the applicant/participant's mental health, substance abuse, and corrections conditions. This information is gathered for the purpose of evaluating criteria for admission into Mental Health Court; preparing a case plan for Mental Health Court and to check progress and compliance with the terms of Mental Health Court. I understand that redisclosure of this information by the authorized participating agencies is prohibited, except as permitted by applicable federal and state laws. Once the requested information has been disclosed, the recipient of the information may re-disclose it and the privacy regulations guaranteed with this consent to release information, may not longer protect the information. However, filings with the Clerk of Court will have a level of security to prevent public access.

This authorization will automatically expire in twenty-four (24) months from the date of my signature, except as hereby specified: _____(list specific number of days or months). At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent

at any time by sending a written notice to the Director of Medical Records of each of the participating agencies whom I have authorized above. I understand that any disclosure or release of information which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality and that my protected health information may be subject to redisclosure and may no longer be protected by the HIPAA privacy provisions. I further understand that I may inspect the information disclosed by any of the participating agencies by contacting the Director of Medical Records at each such agency. I understand that a medical release is normally 6 months but by my voluntary participation in Mental Health Court-the supervision has a minimum of 12 months. This authorization will automatically expire upon the completion of correctional supervision (institutional or community based).

I understand that if the person or entity listed above is a physician; surgeon; physician's assistant; advanced registered nurse practitioner or mental health professional this authorization also permits _____ to consult with the provider about my medical history and condition relating to my diagnosis; evaluation; treatment; progress notes; attendance and compliance (with medication as well as other therapeutic treatment);and any other information relied upon which bears upon conditions of eligibility; conditions of care plan; or progress/compliance for the Southwest Iowa Mental Health Court.

Signature of Mental Health Court applicant/participant

Date

Attorney for Applicant/participant

Date

Specific Authorization For Release Of Information

Protected by State Or Federal Law, 42 CFR Part 2

I specifically authorize the release of information relating to:

(Applicant/participant must initial appropriate line(s))

- Substance Abuse (alcohol/drug abuse)**
- Mental Health (including psychological testing)**
- Acquired Immune Deficiency Syndrome (AIDS) including Human Immunodeficiency Virus (HIV) test results**

Signature/Date

In Order For The Above Information To Be Released, You Must Sign Here And In the Next Column.

Signature of applicant/participant or Authorized Representative

Relationship, if not the applicant/participant

Address

Date

Copy given to applicant/participant on

(date)

by _____

Information released on _____ **(date)**

by _____

to _____
