Southwest Iowa Mental Health Court

Interagency Release of Information 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 <u>initialed</u> 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 (all services and locations), 515 E. Broadway, Council Bluffs, IA 51503**
_____ **Jennie Edmundson Hospital, 933 E. Pierce St, Council Bluffs, IA 51503**
_____ **Mercy/CHI Hospital, 800 Mercy Dr., Council Bluffs, IA 51503**
_____ **CHI 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 member of MHC team**
_____ **Lasting Hope Recovery Center, 415 S. 25th Omaha NE 68131**
_____ **Collaborative Support Team, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Heartland Bridges, 600 9th Ave, Council Bluffs, IA 51503**
_____ **Other:**_____**(family member and/or significant other must include address)**
_____ **Other:**_____**(must include name and/or agency and address)**
_____ **All of the Above Providers**

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: (please initial)

_____ **Attendance and Compliance**
_____ **Discharge Summary**
_____ **History and Physical**
_____ **Medical/Health**
_____ **Lab, X-Ray, EKG**
_____ **Progress Notes**
_____ **Diagnosis & Assessment (for both mental/substance)**
_____ **Insurance coverage/funding sources**
_____ **Emergency Room Report**
_____ **Pathology Report**
_____ **Consultations**
_____ **Educational records**
_____ **Other information as needed (specify)** _____
_____ **On-going progress communication**

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 re-disclosure 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 no 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 twelve (12) 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 re-disclosure 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**

_____ _____

Signature of 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 <u>And</u> 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 _____
_____