MAIN OFFICE:
LE MARS
180 10th St. SE, Suite 201
P.O. Box 70 • Le Mars, Iowa 51031-0070
712-546-4624 • 1-800-325-1192
FAX 712-546-9395
www.plainsareamentalhealth.org

AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MENTAL HEALTH INFORMATION

TO:____
Agency/individual

____
Street Address

____
City, State, Zip Code

EXPIRATION DATE: I understand that this authorization is effective until the earlier of (i) the termination of all services to Patient, or, (ii) if the following is completed:_______________(date on which this authorization expires).

PHONE NUMBER:___________________________________

FAX NUMBER:______________________________________

REGARDING: CLIENT NAME:____CLIENT DOB:____________________________

PAMHC Service Provider(s):____

The exchange of the following information has been authorized by the above named client:

Yes No
____ ____Psychological Assessment
____ ____Pertinent History
____ ____Discharge or Closing Summary
____ ____Psychiatric Evaluation
____ ____Pertinent Medical Information
____ ____Prognosis or Response to Treatment

FAXED information accepted as original.

Information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Privacy Rule.

I understand that PAMHC may not refuse treatment to me if I refuse to sign this authorization.

Other:____

The purpose or need for the disclosure of the above information is:____

____

Signature of Client or Authorized Representative:____

Date Signed:____

I understand that I may revoke this Authorization at any time by giving written notice to Plains Area Mental Health Center.

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SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW

I specifically authorize the release of information relating to:
(Client must <u>initial</u> appropriate items)
___Mental Health Information
___Substance Abuse (alcohol/drug abuse - client must initial & sign regardless of age) ________________________________
Client Signature
___HIV Information
____Genetic Information (Genetic Testing, Genetic Counseling or Education)

____
Signature of Client or Authorized Representative - Date

____
Address City State

_____ I understand that I may review the disclosed information with professional staff. ____Yes ____No

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Confidentiality of mental health information is protected by federal and state law, i.e. Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Prt.2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.
10/12/15kk