



MAIN OFFICE:
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AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MENTAL HEALTH INFORMATION- INDIVIDUAL GENERAL

TO: _____
 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: FAXED information accepted as original.

- | | | |
|-----|-----|---|
| Yes | No | 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 unless protected under Federal 42 CFR Part 2. |
| ___ | ___ | |
| ___ | ___ | |
| ___ | ___ | |
| ___ | ___ | |
| ___ | ___ | |

Other: _____

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

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

Signature of Client: _____

Date: _____

(Client must sign regardless of age)

Signature of Authorized Representative: _____

Date: _____

(Parent/Guardian signature is not required for Juveniles to seek out SUD services under Part 2, but is required for MH services)

Relationship to Client: _____

(If signed on behalf of client)

I understand that I may revoke this authorization at any time by giving written Health Center except to the extent that action has been taken in reliance on it.

Signature of PAMHC Staff Witness: _____

Notice to Plains Area Mental

Date: _____

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

I specifically authorize the release of information relating to the below health care records unless otherwise noted:

___ **Mental Health Information** ___ **Substance Abuse** ___ **HIV Information**

___ **Genetic Information (Genetic Testing, Genetic Counseling or Education)**

___ I understand that I may review the disclosed information with professional staff. ___ Yes ___ No

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 Part 2, and cannot be further disclosed without the written consent 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 substance use disorder patient. Unauthorized disclosure may result in civil damages and criminal penalties.