PLAINS AREA
Mental Health Center
Helping People Cope with Everyday Living

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 BEHAVIORAL HEALTH INFORMATION
FINANCIAL AND PAYMENT

TO:_____
Agency/Third Party Payee

_____
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: _____ DATE OF BIRTH: _____

AUTHORIZE: PLAINS AREA MENTAL HEALTH

TO DISCLOSE: Any such information from my medical record as may be necessary for the completion of claims for reimbursement to my insurance company, preferred provider organization, health maintenance organization, utilization review organization or agency. I understand I am authorizing disclosure which includes mental health, and substance use disorder records which are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that the disclosures may include: diagnosis or procedures performed and at the request of the insurance company, preferred provider organization, health maintenance organization, utilization review organization or agency, my complete record may be subject to review.

I am also providing disclosure permission to release any necessary information to Hawkeye Adjustment Services, Sioux City, IA for the purpose of collection if I fail to comply with my payment agreement. Information to be disclosed to the collection agency includes demographic information and outstanding balance. Attempts to collect unpaid insurance deductible or co-pays will be made prior to disclosure to the collection agency.

FAXED information accepted as original.

I understand that that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I further understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I assign all insurance benefits due me to PLAINS AREA MENTAL HEALTH.

Signature of Patient:_____ **Date:**_____

Signature of Parent/Guardian:_____ **Date:** _____

Signature of Plains Area Mental Health Staff: _____ **Date:** _____

_____ 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 Prt. 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.

PAMHC Authorization Revised 6-11-18

SATELLITE OFFICES:

CARROLL
P.O. Box 794
Carroll, IA 51401-0794
712-792-2991

CHEROKEE
P.O. Box 972
Cherokee, IA 51012-0972
712-225-2575

IDA GROVE:
P.O. Box 168
Ida Grove, IA 51445-0168
712-364-3500

ORANGE CITY
P.O. Box 70
Le Mars, IA 51031-0070
800-325-1192

STORM LAKE
P.O. Box 150
Storm Lake, IA 50588-0150
712-213-8402

DENISON
P.O. Box 426
Denison, IA 51442-0426
712-263-3172