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

TO:____

EXPIRATION DATE: I understand that this authorization is effective Individual 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).

____
Street Address

PHONE NUMBER:_____________________________________

____
City, State, Zip Code

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
____ ____Psychological/Comprehensive Assessment
____ ____Pertinent Social History
____ ____Discharge or Closing Summary
____ ____Psychiatric Evaluation
____ ____Pertinent Medical Information
___ ____Prognosis or Response to Treatment (Progress Summary)
____ ____Involvement in Treatment

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.

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

Other:____

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

I understand that I may revoke this authorization at any time by giving written

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)
Signature of PAMHC Staff Witness:____ Date:__________________
Health Center except to the extent that Notice to Plains Area Mental action has been taken in reliance on it.

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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 the below health care records with INITIALS
_____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

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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 further disclosed without the written consent to whom it pertains or as other wise 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 7.8.20 kd