CONSENT TO RELEASE INFORMATION

Plains Area Mental Health Center
180 10th St. SE. Suite 201
P.O. Box 70 Le Mars, Iowa 51031
Phone: 712-546-4624 Fax: 712-546-9395

Client's Legal Name: _____ DOB: _____

By signing this form, I am allowing Plains Area Mental Health Center to RELEASE ☐ or OBTAIN ☐ written and oral information by telephone, fax, electronic data exchange or mail concerning the above named client with the following individual or agency:

_____ (____)_____
Name of Person and or/ Institution Phone Number

_____ _____ _____ (____)_____
Address City State Zip Code Fax Number

Check the Information to be disclosed:

- ☐ Psychiatric Evaluation
- ☐ Initial Assessment (CDE)
- ☐ Psychological Evaluation
- ☐ DOT/SUD Evaluation
- ☐ Psychiatric Notes
- ☐ Laboratory Results
- ☐ Billing Information
- ☐ Treatment Plan/ Diagnosis
- ☐ Treatment Summary
- ☐ Discharge Summary
- ☐ Clinical Notes
- ☐ Medication List
- ☐ Social History
- ☐ Appointment Dates
- ☐ All of the above
- ☐ Other: (Please Specify) _____

Please indicate the reason for release:

☐ Continuity of Care ☐ Rehab/Disability ☐ Legal ☐ Insurance ☐ Transferring Care
☐ Other: (Please Specify) _____

This authorization is voluntary. I understand that I may revoke this consent at any time except to the extent that action has been taking in reliance on it. If I choose to revoke this consent, I must send written notification to: Medical Records, Plains Area Mental Health Center. If I revoke this consent, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address. Confidentiality of the information is protected by Federal Law (42-CFR-Part 2) and the code of Iowa Chapter 228. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Part 2 re-disclosure is prohibited, unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Part 2 (42 CFR § 2.32).

I understand that Plains Area Mental Health Center may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization, except that a) Plains Area Mental Health Center may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research, and b) Plains Area Mental Health Center may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on the provision of authorization for that third party.

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

I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____Substance Abuse _____Mental Health _____HIV-related Information _____Genetic Tests/Info

If I do not revoke consent, this release will expire no more than one year from the date below, or on date specified here:_____

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian/Representative Signature Relationship to Client Date

_____ _____
Signature of PAMHC Staff Witness Date

Only clients 18 years of age or older, or legal representative, can authorize release of mental health information. Only clients, regardless of age, can authorize release of substance abuse information.