**Vera French Community Mental Health Center**

**Authorization to Release/Obtain Information**

| IDENTIFYING INFORMATION | | | |
|---|---|---|---|
| NAME | DOB | | CASE # |
| ADDRESS | | | |

TENTATIVE EFFECTIVE DATE

**I hereby authorize Vera French Community Mental Health Center (VFCMHC) to release and/or obtain information concerning the named client with:**

**THE INFORMATION BEING RELEASED AND/OR REQUESTED WILL BE USED FOR THE FOLLOWING PURPOSE(S):**

- ☐ Ongoing evaluation and treatment
- ☐ Coordination of services and supports
- ☐ Coordination of medical treatment
- ☐ Referral
- ☐ Academic planning and placement
- ☐ Personal file
- ☐ Litigation/Court
- ☐ Insurance supports
- ☐ Other:

**RELEASE THE FOLLOWING INFORMATION:**

- ☐ Exchange all written & verbal health information pertinent to the coordination of my care & treatment
- ☐ Mental Health Evaluations
- ☐ Psychiatric Diagnostic Evaluations
- ☐ Medication Management Notes
- ☐ Treatment/Service Plan
- ☐ Progress Notes/Records of Contact
- ☐ Therapy Notes
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Contact Information
- ☐ Laboratory Testing Results
- ☐ Medication List
- ☐ Other:

SPECIFY DATES OF SERVICE (IF NEEDED):

**OBTAIN THE FOLLOWING INFORMATION:**

- ☐ Hospital/Medical Records
- ☐ Social & Family History
- ☐ Health & Treatment History
- ☐ Evaluation Results
- ☐ Records of Contact/Service Notes
- ☐ Discharge Summary
- ☐ Medication List
- ☐ Prognoses/Treatment
- ☐ Legal Status/Legal History
- ☐ Grades, Test Scores, Conduct, Attendance
- ☐ Educational/Vocational Plans
- ☐ Phone Contact
- ☐ Other:

SPECIFY DATES OF SERVICE (IF NEEDED):

**MY HIGHLY CONFIDENTIAL INFORMATION:**

I specifically authorize the use and/or disclosure of the type of highly confidential information indicated below, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about Substance (i.e., alcohol or drug) Abuse, including SUD counseling notes, assessments, diagnoses, treatment plans, medication-assisted treatment documentation, and discharge summaries.
- ☐ Information about a Mental Illness or Developmental Disability
- ☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted infection
- ☐ I do not authorize the disclosure of my highly confidential information

This authorization is voluntary and I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it. by sending written notice to the VFCMHC. I understand the person or agency receiving this information will be notified not to disclose this information without further written consent. I understand that VFCMHC cannot guarantee that the recipient will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information.  The confidentiality of Substance Use Disorder (SUD) patient records is protected by federal law (42 CFR Part 2). Records disclosed pursuant to this authorization may be redisclosed by recipients that are covered entities or business associates under HIPAA in accordance with the HIPAA Privacy Rule. However, SUD records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the patient without the patient's specific written consent or a court order. Any release made prior to my cancellation of this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting the VFCMHC at the above address.

I understand that this health information may include information relating to diagnosis or treatment of psychiatric disabilities, substance abuse, and/or information about serious communicable diseases or infections including HIV/AIDS, ARC, TB, Hepatitis B and venereal disease as permitted by law, and that by signing this form, I am specifically authorizing the release of this information.

I understand that VFCMHC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services.

I understand that I have the right to request an accounting of disclosures of my substance use disorder information made pursuant to this authorization for up to three (3) years prior to the date of my request, as permitted under 42 CFR Part 2.

I understand that I may file a complaint with the U.S. Department of Health and Human Services if I believe my confidentiality rights under 42 CFR Part 2 have been violated. I understand that I will not be retaliated against for filing a complaint.

| THIS AUTHORIZATION WILLEXPIRE ON (date): |
| --- |

| A COPY OF THIS DOCUMENT WAS OFFERED AND THE CLIENT: |
| --- |
| ☐ Received Copy<br>☐ Declined Copy |

**NOTE TO THE RECIPIENT OF DISCLOSED MENTAL HEALTH INFORMATION:**

Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in Iowa Code 228. The unauthorized release of mental health information is unlawful, and civil damages and criminal penalties may be applied to the unauthorized disclosure of mental health information.

**The confidentiality of substance use disorder patient records is protected by federal law and regulations, including 42 CFR Part 2.**
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from using or disclosing this information unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 investigate or prosecute a patient with a substance use disorder, except as permitted by law. The confidentiality of problem gambling patient records and information is protected by HIPAA, Iowa Code Charter 228 and Iowa Code section 22.7(35).

STAFF SIGNATURE / CREDENTIALS ________________ DATE ________

CLIENT SIGNATURE ________ PRINTED NAME ________ DATE ________