AUTHORIZATION TO RELEASE INFORMATION

The undersigned does hereby grant permission for the following indicated release of information relating to:

NAME: ______________________ **DOB:** ______________

Address: ______________________ **Phone:** ______________

Check Applicable Option(s)

- ☐ Family Resources
- ☐ Four Oaks
- ☐ Affordable Housing Network
- ☐ Jane Boyd

This authorization applies to records maintained by the following (select above), to release information to:

Person/Position: ______________________________

Agency/Organization: ______________________________

Phone/Fax: ______________________________

Statement of Purpose for Release of Information

- ☐ Assessment
- ☐ Service Planning
- ☐ Service Coordination
- ☐ Discharge/Aftercare Planning
- ☐ Legal
- ☐ Other ______________

The information subject to this release is as follows:

- ☐ Social/Family History and/or other background information
- ☐ Medical History/Discharge
- ☐ Opinions
- ☐ Progress Reports or Summaries
- ☐ Other ______________________
- ☐ Other ______________________

Release of the following information MUST be specifically authorized by a separate signature below:

☐ Information relating to HIV/AIDS:

Signature ______________________

☐ Substance Abuse Information

Signature ______________________

☐ Mental Health

Signature ______________________

☐ Genetic Testing

Signature ______________________

Please see reverse for signatures

AUTHORIZATION TO RELEASE INFORMATION

By signing this document, I acknowledge I understand that the release or exchange of information may be verbal, written, or by reproduction of written materials, any of them being an acceptable method.

My rights concerning this release of information have been explained to me as follows:
* I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations. I also acknowledge that the recipients of this information may possibly re-release the information without proper authorization.
* This authorization may be revoked at any time by signing the revocation statement in this document. The release expires one (1) year from signing.
* A copy of this release shall accompany all disclosed information and shall be included in records so as to identify the material disclosed.

* I understand that authorizing the disclosure of this health information is voluntary. Signing this form is not required. I do not need to sign this form to receive treatment.

I acknowledge that I have read and understand this document, that I was not signed in blank, and that if I am signing as legal representative of a minor who is not legally competent that I am in fact the fully authorized representative of that person.

______________________________ ______________________

Client Signature **Date**

______________________________ ______________________

Legal Representative **Date**

**Notice to Receiving Person/Agency/Entity: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly avoidable information. or through verification of such identification by another person unless further discloses 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 (SS 2.31). The federal rules restrict any use of this information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at SS 2.12(c)(5) and 2.65. See also Chapter 228 and Chapter 141 (A) for Iowa Code and other applicable laws.*

This release is valid for 365 Days OR until ______________ **(enter a date less than one (1) year)**
For Survivor Services Programs Only, this release is valid for 90 days OR until ______________ **(not to exceed 365 days)**

Revocation

I understand that I may cancel or revoke this authorization at any time by sending a written notice to the entity I identified above. Upon
I hereby revoke this authorization on this date: ______________

Signature: ______________________

Revised 11/18