Southern Iowa Mental Health Center – Release of Information

1527 Albia Road. Ottumwa, Iowa 52501
Phone: 641-682-8772. Fax: 641-682-1924
Email: Simhc@SimhcOttumwa.Org

Patient Name: ________________________________ Date of Birth: ____________________ SSN: ________________

I hereby grant authority for Southern Iowa Mental Health Center to release and/or obtain information from:

Organization: ____

Full Address: ____

Phone: ____ Fax: ________________

I agree that Southern Iowa Mental Health Center may release and/or obtain the following information from the patient record:

_______Discharge Summary
_______Psychiatric Reports
_______Psychological Reports
_______Progress Notes
_______Assessments
_______Social Worker Reports
_______Treatment Status
_______Social History
_______Medical Records
_______DSM Diagnosis and Date of Diagnosis
_______Other (Specify)______________________________________

The information being released will be used for the following purposes:

_______Coordination of Services
_______Referral for New Services
_______Monitoring of Services
_______Documentation of County of Legal Settlement
_______Other (Specify)____

I UNDERSTAND THAT THE INFORMATION YOU RELEASE OR OBTAIN WILL BE USED AS APPROPRIATE AND NECESSARY FOR MY TREATMENT AND DOES NOT CONSTITUTE BREACH OF MY RIGHTS TO CONFIDENTIALITY.

____

Signed   Date

This authorization is effective for _____months, or one year from the date signed, whichever comes first. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Southern Iowa Mental Health Center. I understand that I have the right to inspect the information to be disclosed upon proper notification to, and under appropriate conditions established by, Southern Iowa Mental Health Center. I understand that my refusal to sign this or any release of information shall not interfere with my ability to receive care from this facility.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW.

I specifically authorize the release of date and information relating to (check appropriate line):

1. Alcohol & Drug Abuse: _____
2. Mental Health: ______
3. HIV Related Information: _____
4. Genetic Testing (G.I.N.A.)_____
5. Developmental Disabilities: _____

____
Signature of Client or Authorized Representative   Date

____
Relationship of Representative

____
Signature of Witness

PROHIBTION ON RE – DISCLOSURES:

This information may have been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and Iowa Code C. 228. A general authorization for release of records is NOT sufficient for you, in turn, to disclosed or release this information. This report is strictly confidential and is for the information only of the person/agency to whom it is addressed. No responsibility can be accepted if it is made available to any other person, including the patient.

Copy of Release Given to Client?

Yes ☐   Client Denied ☐

A photocopy, or exact reproduction of this authorization, as duly executed, shall have the same force and effect as the original.