

Release of Information

CLIENT	
ADDRESS:	DATE OF BIRTH:
I, the undersigned, hereby authorize the staff of Care Connections of Northern Iowa to release and / or obtain the information indicated below, regarding the above named consumer, with:	
obtain the information indicated below, regarding the ab	ove named consumer, with:
Name of Person or Agency	
Complete Mailing Address	
The information being released will be used for the followall Planning and implementation of Services	wing purpose: Referral for new or other services
Coordination of services	Other (Specify)
Monitoring of services	
Your eligibility for services or funding is is is not d	ependent upon signing this release. {See CFR
164.508(b)(4)}	
INFORMATION TO BE RELEASED FROM	INFORMATION TO BE OBTAINED FROM
COMMUNITY SERVICES:	THE AGENCY INDICATED ABOVE:
	Yes No SOCIAL HISTORY
☐ SOCIAL HISTORY☐ PROGRESS SUMMARY REPORT	SOCIAL HISTORY DEDUCATIONAL/VOCATIONAL PLANS
☐ ☐ INDIVIDUAL COMPREHENSIVE PLAN	☐ ☐ PROGRESS SUMMARY
ANNUAL REVIEW	PSYCHOLOGICAL EVALUATION/ REPORTS
☐ ☐ DISCHARGE SUMMARY	PSYCHIATRIC ASSESSMENT / REPORTS
☐ RE-RELEASE OF 3 RD PARTY INFO (Specify)	☐ MEDICAL HISTORY
(Your information will not be re-released without a signe	
TREATMENT PLAN	DISCHARGE SUMMARY
OTHER (Specify)(Specify)	☐ ☐ RE-RELEASE OF 3 RD PARTY INFO☐ ☐ FINANCIAL DOCUMENTATION
(Specify)	OTHER (Specify)
This authorization shall expire on:	(Not to exceed 12 months)
At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Care Connections of Northern Iowa. I understand that any information released prior to the revocation may be used for the purposes listed above and does not constitute a breach of my rights to confidentiality. I understand that any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named of Care Connections of Northern Iowa. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: I specifically authorize the release of data and information relating to Mental Health. Signature of Client or Legal Guardian:	
SPECIFIC AUTHORIZATION FOR RELEASE OF INFO	RMATION PROTECTED BY STATE OR
FEDERAL LAWS:	nation relating to.
I specifically authorize the release of data and inform	nation relating to:
☐ Substance Abuse (must be signed by the consumer	HIV-Related Information
Client Signature Date In order for this information to be released, you must signature	Guardian Signature Date In here and on the signature line above.
Copy given to Client on: OR	Client refused copy on: