

Authorization for the Use or Disclosure of Confidential Information

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 35B, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Client #: \_\_\_\_\_

Address: \_\_\_\_\_

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, law enforcement agencies, and community non-profit agencies providing financial assistance (a list of the current affiliated case management entities, law enforcement agencies, community non-profit agencies providing financial assistance and other providers is available upon request), and these specifically identified entities: \_\_\_\_\_, with the exception of the following Iowa counties, Regions or other entities: \_\_\_\_\_.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Table with 2 columns: Information to be disclosed includes, For the following purposes. Row 1: Law enforcement agencies, providers or agencies who have arranged with the counties or Regions to perform related duties... vs. In keeping with national, state and local efforts to enhance care coordination... Row 2: To Iowa counties and Regions listed on Exhibit A, case management agencies... vs. Parties will access/disclose records for the purposes of: coordinating treatment, paying claims...

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

I hereby specifically authorize the release and sharing of information with Iowa Counties and Regions listed on Exhibit A, case management agencies, and/or the specifically identified entities from above, relating to: (check any that apply)
NOTE: This authorization for release of information does not authorize the release and/or sharing of information relating to substance use disorder treatment.

- Input boxes for: HIV/AIDS Related Testing Information, Mental Health Information (NOTE: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:

Input box: \_\_\_/\_\_\_/\_\_\_ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to \_\_\_\_\_, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the client, please indicate relationship:

- Input boxes for: parent or guardian of minor client, guardian or conservator of a client (if and to the extent authorized under State law), personal representative of deceased client, other (specify) \_\_\_\_\_

Copy sent to Client/Guardian on: \_\_\_\_\_ (date) at following address: \_\_\_\_\_

**A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE**

**Notice to Recipients of Mental Health Information:** In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

**Notice to Recipients of HIV-Related Testing Information:** This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

**EXHIBIT A**

<u>Iowa Counties:</u>	Floyd	Monroe	<u>Iowa Mental Health and Disability Services Regions:</u>
Adair	Franklin	Montgomery	Care Connections of Northern Iowa
Adams	Fremont	Muscatine	Central Iowa Community Services
Allamakee	Greene	O'Brien	County Rural Offices of Social Services
Appanoose	Grundy	Osceola	County Social Services
Audubon	Guthrie	Page	Eastern Iowa MHDS
Benton	Hamilton	Palo Alto	Heart of Iowa Community Services
Black Hawk	Hancock	Plymouth	Mental Health Agency of Southeast Iowa
Boone	Hardin	Pocahontas	MHDS of the East Central Region
Bremer	Harrison	Polk	Polk County Behavioral Health and Disability Services
Buchanan	Henry	Pottawattamie	Rolling Hills Community Services
Buena Vista	Howard	Poweshiek	Sioux Rivers MHDS
Butler	Humboldt	Ringgold	Southern Hills Regional Mental Health
Calhoun	Ida	Sac	Southwest Iowa MHDS
Carroll	Iowa	Scott	
Cass	Jackson	Shelby	
Cedar	Jasper	Sioux	
Cerro Gordo	Jefferson	Story	
Cherokee	Johnson	Tama	
Chickasaw	Jones	Taylor	
Clarke	Keokuk	Union	
Clay	Kossuth	Van Buren	
Clayton	Lee	Wapello	
Clinton	Linn	Warren	
Crawford	Louisa	Washington	
Dallas	Lucas	Wayne	
Davis	Lyon	Webster	
Decatur	Madison	Winnebago	
Delaware	Mahaska	Winneshiek	
Des Moines	Marion	Woodbury	
Dickinson	Marshall	Worth	
Dubuque	Mills	Wright	
Emmet	Mitchell		
Fayette	Monona		

**REVOCACTION SECTION**

I hereby revoke this Authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Copy sent to Client/Guardian on: \_\_\_\_\_ (date) at following address: \_\_\_\_\_ v15, Approved 1.19.24