Iowa Department of Human Services

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Client Name:	ID#:	SS#:
Date of Birth:	Parent/Guardian:	

I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive . . .

Name or agency to release and receive information: Iowa Department of Human Services, TPL	
Address: PO Box 36475	
City/State/Zip: Des Moines, IA 50315	
Phone: 866-810-1206	Fax:

With the following individual or agency:

Name or agency to receive and release information: Lien Resolution Group	
Address: 55 Old Nyack Turnpike Rd. Ste. 311	
City/State/Zip: Nanuet, NY 10954	
Phone: 845-638-1278	Fax: 845-638-1237

The information released or shared may include: ☐ Face sheet ☐ Admission status ☐ Psychological reports

☐ Discharge summary ☐ Family data photos ☐ Social history ☐ Lab results ☐ Treatment and aftercare plans

☐ Diagnosis/allergies ☐ X-ray/imaging reports ☐ Team notes ☐ Medication history ☐ History & physical exam

☐ Initial assessment ☐ Immunization record ☐ School records ☐ Court documents ☐ Evaluation & recommendations

☐ Receiving phone calls

☐ Consultation reports from (doctor/specialty name): ______________________________

☐ Other (please specify): ______________________________

Other (note exceptions or limits to this release):

This information is being used ONLY for (state purpose):

SPECIFIC AUTHORIZATION FOR RELEASE	**Type of Information**	**Authorizing Initials**
I authorize the release of the information listed at the right, which requires specific consent under federal law:	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (name) ______________________________ at (phone) ______________________.
I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	Date:	Expiration date:
Relationship to client: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other (specify below)		
☐ Not Required	Witness signature:	
☐ Required	Witness signature:	

A photocopy of this signed authorization shall have the same force and effect as this original.

RECORD OF DISCLOSURES

(Required for mental health information)

	Date	Name of Recipient	Contents Disclosed	Sent By
1.				
2.				
3.				
4.				
5.				

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION

In accordance with "Disclosure of Mental Health and Psychological Information" (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 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENTS OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE TO RECIPIENTS OF HIV-RELATED TESTING INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

POLICY ON NONDISCRIMINATION

No person shall be discriminated against because of race, creed, color, sex, age, physical or mental disability, religion, national origin or political belief regarding employment or when applying for or receiving benefits or services from the Iowa Department of Human Services, the county, or any of their vendors, purchased service providers, or contractors.

If you have reason to believe that you have been discriminated against for any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services (IDHS) by completing a Discrimination Complaint form. Any IDHS office, institution, or the IDHS Diversity Programs Unit can provide you with this form. If you have reason to believe that you have been discriminated against by a county for any of the reasons stated above, you may contact that county. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were discriminated against **because of** your race, creed, color, national origin, sex, religion, or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

For assistance or consultation you may contact the IDHS Diversity Programs Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act.

Iowa Department of Human Services
Diversity Programs Unit 1st Fl
1305 E Walnut St
Des Moines IA 50319-0114

Iowa Civil Rights Commission
400 E 14th St
Des Moines IA 50319-1004

County Central Point of Coordination Administrator

US Dept. of Health and Human Services
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106-2808
(FIP, Medical and Services only)