Providence Place
Release of Information

I,_____, authorize _____ at

_____ phone _____

to release and exchange information with:

_____

408 SE 2nd Street
Grimes, Iowa 50111
515-986-7255
515-986-0500 fax

Regarding:

(Name) _____ DOB _____. This information is pertinent to the client's mental health, behavioral or academic needs as deemed by either agency. This information may contain copies of discharge summaries, clinical notes or diagnostic tests or assessments, pertaining to the client's evaluation and treatment. It may also include progress and attendance of treatment. This release may be requested for additional purposes or include additional information as specified.

The information shared may be written and/or verbal and it may be currently in existence and/or that which is made in the future. This information will only be shared with appropriate personnel on a need to know basis. This authorization is good for one year from the date signed. I understand I may revoke this authorization at any time by giving written notice to **Either party**.

I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Specific Authorization for Release of Information protected by State/Federal Law
I specifically authorize the release of data and information relating to :
(please initial each specification)

_____ Substance abuse _____ HIV/AIDS _____ Mental Health _____ Other _____

_____ Date _____
Signature of Client/parent/legal representative

_____
Witness

PROHIBITION OF REDISCLOSURE: This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42C.F.R Part 2) and state requirements (Iowa code ch. 22) prohibits further disclosure without the specific written consent of the client or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

*Only persons 18 years of age or his/her legal representative may authorize release of mental health information.

** Only the subject may authorize release of substance abuse information unless the subject is under legal age or incompetent as defined by statue.

Sharing information: It is the responsibility of all agencies listed to provide requested information. The recipient of the information is responsible for maintaining confidentiality of the information.

Contact Information:

Name: _____

Phone Number: _____