Release of Information Form

AUTHORIZATION TO RELEASE, OBTAIN, OR EXCHANGE INFORMATION

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MATERNAL CHILD HEALTH OF SW IOWA
c/o Taylor County Public Health
405 Jefferson Street; Suite 7
Bedford, Iowa 50833

CLIENT NAME:_____CLIENT CHART NUMBER:_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Reason for request to release information: _____

I VOLUNTARILY AUTHORIZE Taylor County Public Health Agency and its subcontractors: Page County Public Health; PHN Services of Montgomery County; SW Iowa Home Health to release, obtain, or exchange information with the following: physicians, primary care practitioner, dentists, preschool/daycare, school nurse, WIC, (other, specify)_____. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health, and/or AIDS-related information.

I authorize the release and exchange of the following information:

☐ General Medical Care:_____ ☐ School Records:_____

☐ Social and Family History:_____ ☐ Other:_____

Specific Authorization for Release of Information Protected by State or Federal Law :
I acknowledge that information to be released may include material that is protected by federal and/ or state law applicable to substance abuse, mental health, and/ or HIV/AIDS – related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Please check the applicable boxes.]

Mental Health* yes ☐ no ☐	Substance Abuse** yes ☐ no ☐	HIV/AIDS yes ☐ no ☐
Signature:_____	Patient Signature:	Signature:_____
Relationship:_____	_____	Relationship:_____

Note in order for this information to be released you must sign here and on the bottom of this page:

Signature: _____

*Only client 18 years of age or emancipated teenager, or legal representative can authorize release of mental health information.

**Only client, regardless of age, can authorize release of substance abuse information.

I UNDERSTAND that the AUTHORIZATION TO RELEASE, OBTAIN, OR EXCHANGE INFORMATION form is limited to the agencies, groups, or persons named; and this information is not to be passed on to anyone else or to be used for any purpose other than those specified.

I understand that I have the right to see this information at any time. I can revoke my consent by writing to both the persons giving and the persons receiving the information. However, any information already released may be used as stated on this authorization form. I understand the information is needed to plan services or to determine eligibility for services. This authorization is effective for no longer than one year from the date of signature or for _____ months. This authorization is not automatically renewable. It expires from the date of signature. I have read this release or it has been read to me, and I understand its content. Photocopies of this release will be as valid as the original.

I certify that any person(s) who furnish such information concerning me shall not be held accountable for providing this information, and I do hereby release said person(s) from any and all liability which may be incurred as a result. I further release the Iowa Department of Public Health from any and all liability which may be incurrent as a result of collecting or disclosing such information.

Note: See disclosure and re-disclosure on back side of this page before signing.

Signature of Client or Representative:_____ Date:_____

Relationship of Authorized Representative:_____ Date:_____

Disclosure and Re-disclosure

Iowa and federal law provides that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit additional disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate of prosecute any alcohol or drug abuse patient.

See also Iowa Code Chapters 141A and 228.0 and other applicable laws.

This form does not authorize re-disclosure of medical information beyond the limits of the consent.