Northwest Iowa Care Connections
Release of Information

For individuals living in: Clay, Dickinson, O'Brien, Osceola, and Palo Alto Counties

CLIENT _____
ADDRESS:_____DATE OF BIRTH: _____

I, the undersigned, hereby authorize the staff of Northwest Iowa Care Connections to release and / or obtain the information indicated below, regarding the above named consumer, with:

Name of Person or Agency

Complete Mailing Address

The information being released will be used for the following purpose:

☒ Planning and implementation of Services
☒ Coordination of services
☒ Monitoring of services
☒ Referral for new or other services
☐ Other (Specify)_____
_____

Your eligibility for services or funding ☐ **is** ☒ **is not** dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM COMMUNITY SERVICES:

Yes	No	
☐	☒	SOCIAL HISTORY
☐	☒	PROGRESS SUMMARY REPORT
☐	☒	INDIVIDUAL COMPREHENSIVE PLAN
☐	☒	ANNUAL REVIEW
☐	☒	DISCHARGE SUMMARY
☐	☒	RE-RELEASE OF 3RD PARTY INFO (Specify)

(Your information will not be re-released without a signed authorization)

_____

☐ ☒ OTHER (Specify)_____
_____

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

Yes	No	
☒	☐	SOCIAL HISTORY
☒	☐	EDUCATIONAL / VOCATIONAL PLANS
☒	☐	PROGRESS SUMMARY
☒	☐	PSYCHOLOGICAL EVALUATION / REPORTS
☒	☐	PSYCHIATRIC ASSESSMENT / REPORTS
☒	☐	MEDICAL HISTORY
☒	☐	TREATMENT PLAN
☒	☐	DISCHARGE SUMMARY
☐	☒	RE-RELEASE OF 3RD PARTY INFO (Specify)
☒	☐	FINANCIAL DOCUMENTATION
☐	☒	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 Northwest Iowa Care Connections. 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 or Northwest Iowa Care Connections.

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: _____ _____
Date

_____
Relationship if NOT The Client

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAWS:
I specifically authorize the release of data and information relating to:

☒ Substance Abuse (must be signed by the consumer)
☒ HIV-Related Information

_____ _____ _____ _____
Client Signature **Date** **Guardian Signature** **Date**

In order for this information to be released, you must sign here and on the signature line above.

Copy given to Client on:_____ *OR* Client refused copy on:_____