HCCMS Family Health Services

Crawford County Home Health, Hospice & Public Health
105 N. Main Street Denison, IA 51442
Harrison, Cass, Crawford, Monona, & Shelby County Clinics

Release of Information

Client's Name *(first, middle, last)*: DOB:

Address: City/State: Zip:

I voluntarily authorize **HCCMS Family Health Services** staff to release, obtain, and exchange information with the individuals or agencies listed below:

Name/Agency	Address	Phone

I authorize the release and exchange of the following information for the purposes of continued care/updating records:

☐ General Medical Care ☐ Social/Family History ☐ School Records ☐ Screening Results
☐ Insurance Provider: _____ ☐ 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 AIDS-related information. I specifically authorize the release of confidential information relating to: [*Please check applicable boxes*]

Mental Health* ☐ YES ☐ NO

Signature of Client or Parent/Guardian* **Date** **Relationship**

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

Substance Abuse** ☐ YES ☐ NO

Signature of Client ** **Date**

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

HIV ☐ YES ☐ NO

Signature of Client or Parent/Guardian **Date** **Relationship**

I understand that the Release of 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 by used as stated on this 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. This authorizations 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 Parent/Guardian Date

Disclosure and Redisclosure

Iowa and federal law provides that any disclosure or redisclosure 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 redisclosure of medical information beyond the limits of the consent.