INFINITY HEALTH
an iowahealth partner

Authorization for the Release of Medical, Dental, Vision, or Behavioral Information

Patient Name: _____DOB:_____SS#: _____

Phone: (H) _____ (W) _____ (Cell) _____

Address: _____City/State/Zip:_____

This information is to be used for communication and exchange of information between:

Infinity Health	Facility/Person: _____
302 NE 14th Street	Address: _____
Leon, Iowa 50144	City, State, Zip: _____
Phone: (641) 446-2383	Phone: _____
Fax: (641) 446-2382	Email/Fax: _____

voluntarily authorize Infinity Health to disclose and/or receive confidential information to the above individual(s) and I authorize the release of protected confidential information regarding the following (**please initial**): _ Mental Health _ __ Substance Abuse ___ HIV/AIDS

Information is preferred to be given as oral, written format, or digital (please circle one) and will specifically include the following as **marked**:

Yes	No		Yes	No	
___	___	Psychiatric Evaluation/Consultation	___	___	Assessment/Intake
___	___	Psychological Testing	___	___	Outpatient Therapy Notes
___	___	School Records	___	___	Medical Records
___	___	Lab Reports	___	___	AEA Testing/Records
___	___	Foster Care Placement Orders	___	___	In-home Counseling Notes
___	___	Child In Need of Assistance Records	___	___	Psychosocial History
___	___	Discharge Summary	___	___	Other: Patient Information

This information is being disclosed and may be used only for the following purpose(s): ____Coordination of services_____

(Authorization for release of information is effective for 12 months from date of signing)

If I am requesting this Authorization from you for my own use and disclosure or to allow another health care professional or health care entity to disclose information to me or the parties named above: (1) You cannot deny your services or treatment to me if I refuse to make this signed authorization; (2) I have the right to inspect a copy of the protected health information to be used or disclosed; (3) I may refuse to sign this Authorization; and (4) I must provide you with a copy of the signed authorization. I have the right to revoke this authorization at any time, provided that I do so in writing and except to the extent that you have already used or disclosed the information in reliance on the authorization. By signing this authorization, I may be directing you to disclose my health information to a person or organization that does not have the same obligations to protect privacy as required of health care practitioners, health plans and other health care entities observed under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of my protected health information and loss of protection under state and federal law. I may request that you require the recipient of my protected health information to sign a confidentiality agreement in which the recipient agrees to limit use and disclosure of my information as specified by the confidentiality agreement. If the intended recipient refused to sign the confidentiality agreement I requested, you would not have to release the information.

_____ _____ _____
Signature of Patient or Authorized Representative — Relationship to Patient — Date

_____ _____
Witness Signature — Date

PROHIBITION FOR REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal and/or State Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse and State Law (Iowa Code 228 and 141) for Mental Health, and HIV/AIDS treatment, prohibit information disclosed from records protected by these laws from being re-disclosed, even to the patient without the specific written consent of the patient or as otherwise permitted by such laws and/or regulations. A general authorization for the release of medical or other information is **NOT** sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Civil and Criminal Penalties may attach for authorization disclosure of alcohol/drug, mental health, or HIV/AIDS information.

OBTAIN or RELEASE