West Iowa Community Mental Health Center
Authorization to Use/Disclose Information

Name_____Date of Birth_____Record #_____

I, the undersigned, hereby authorize West Iowa Community Mental Health Center to
___ release to ___ obtain from ____ exchange with

_____
Name of Person or Institution

_____
Address **City** **State** **Zip Code**

information concerning the above named individual.

This information is to be used for (please specify reason for the authorization)
Continued Mental Health Care

Information to be used and disclosed includes: (be specific)
Written and verbal communication regarding prescribed medications, diagnosis and assessment of care.

This authorization to use and disclose information will automatically expire **60 days** from the date of signature and/or not to exceed 1 year or except as specified _____ (Use actual dates)

At that time, no express revocation shall be needed to terminate my authorization, but I understand that I may revoke this authorization at any time by sending a written notice to the Director of West Iowa Community Mental Health Center.

I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information, as described in the Privacy Notice.

I understand that treatment is not a condition of signing an authorization, unless treatment is for the sole purpose of creating information for disclosure to a third party and the authorization is for the disclosure of information to that third party.

I understand that information disclosed pursuant to this authorization is subject to redisclosure by the recipient and no longer protected by the Privacy Rule.

SPECIFIC AUTHORIZATION FOR USE & DISCLOSER OF INFORMATION PROTECTED BY STATE FOR FEDERAL LAW
I specifically authorize the use and disclosure of information relating to: (check the appropriate box)

☐	☐	☐
Substance Abuse (alcohol/drug abuse)	Mental Health (including psychological testing)	HIV-Related Information (AIDS related testing)

This information has been disclosed to you from records protected by federal confidentiality rules for alcohol and drug abuse records (42 CFR Part 2), state law for mental health records (Iowa Code CH.228), and /or state law for HIV records (Iowa Code CH. 1421). These rules and laws prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of this information. The federal rules relating to alcohol/drug abuse records restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (issue 6/94)

_____
Signature of Individual or Legal Guardian Date

_____
Relationship If Not The Individual Witness

West Iowa Community Mental Health Center
PO Box 187/Denison, IA 51442/(712)263-3172