

Hills & Dales \*\* 1011 Davis Avenue \*\* Dubuque, Iowa 52001 \*\* 563-556-7878

RELEASE OF INFORMATION

Name: \_\_\_\_\_

Title 19 #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I, the undersigned, hereby authorize Hills & Dales staff to release and/or obtain the information indicated below, regarding the above named individual, with:

(Specialty Physician)
Name of Person or Agency: \_\_\_\_\_
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

INFORMATION BEING RELEASED WILL BE USED FOR THE FOLLOWING PURPOSE(S):

- ( ) Planning and Implementation of Individual Program Plan
( ) Monitoring/Coordination of Services
( ) Referral for New Services
( ) Other \_\_\_\_\_

INFORMATION TO BE RELEASED FROM HILLS & DALES:

- ( ) Social History ( ) Health Related Dictation/Documents
( ) Individual Program Plan/Consultant Reports ( ) Discharge Summary
( ) Educational/Vocational Plans/Evaluations ( ) Other: \_\_\_\_\_

INFORMATION TO BE OBTAINED FROM THE LISTED AGENCY:

- ( ) Social History ( ) Medical History
( ) Individual Program Plan/Consultant Reports ( ) Discharge Summary
( ) Educational/Vocational Plans/Evaluations ( ) Other: \_\_\_\_\_
( ) Health Related Dictation/Documents

This release is valid for 13 months from the date of signature.

I understand that I may revoke this consent at any time by sending a written notice to the recipient and to Hills & Dales. I understand that any information released prior to a revocation may be used for the purposes listed above and does not constitute a breach of my rights to confidentiality. I understand that I may review the information related for the above purposes by contacting, Hills & Dales, 1011 Davis Avenue, Dubuque, Iowa 52001.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Individual or Legal Guardian Signature Date Signed

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

Substance Abuse: ( ) Yes ( ) No Mental Health: ( ) Yes ( ) No HIV/AIDS: ( ) Yes ( ) No

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Individual or Legal Guardian Signature Date Signed

Date copy of this form sent to Individual and/or Guardian: \_\_\_\_/\_\_\_\_/\_\_\_\_