Hills & Dales Child Development Center

Authorization for Release and/or Receipt of Protected Health Information

Name: _____Title 19 #: _____ DOB ___/___/_____

Full Address: _____

Previous Names: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release information From: Primary Physician		**Release information To:**	
Name /Agency		Name /Agency	
		Hills & Dales	
Address		Address	
		1011 Davis Street	
City/State/Zip		City/State/Zip	
		Dubuque, IA 52001	
Phone #	Fax #	Phone #	Fax #
		563-556-7878	563-557-3822

By signing this form, I am allowing Hill & Dales to release or disclose medical information concerning the above named patient to the person or facility above. Viewing may be verbal, copies, or written information of such records.

Purpose of Release

( ) Planning and Implementation of Individual Program Plan
( ) Monitoring/Coordination of Services
(X) Referral for New Services
( ) Other: _____

INFORMATION TO BE RELEASED AND/OR OBTAINED:

Check all that apply

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

List Intended Timeframe for information dates from _____ to _____

This release automatically expires one year from the date of my signature, unless I specify a different event, purpose or alternative date here: ☐ to correspond with annual program plan ☐ Other: _____

This information disclosed to you from records protected by Federal and Iowa State Confidentiality rules CFR 42, Part 2, Iowa Chapter 228, and/or Section 141.23(2) of the Iowa Code. This authorization is voluntary. 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. Hills & Dales will not make the signing of the Authorization for Release and/or Receipt of Protected Health Information a condition of your treatment, enrollment, or eligibility for services.

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

I understand that the information to be disclosed may include information in the following categories and herby specifically authorize such disclosure:

Substance Abuse: **Yes** **Mental Health**: Yes **HIV Related Information**: Yes

IF YOU DO NOT WANT ANY/ALL OF THE ABOVE INFORMATION DISCLOSED, CROSS OUT "YES" AND WRITE "NO" IN THE APPLICABLE SECTION(S).

I authorize the agency/provider to disclose protected health information to the party identified in the "Release Information To" section. I understand this may include information regarding substance abuse, mental health and HIV related information. I understand once disclosed, information may be re-disclosed by the recipient and no longer protected. I may revoke this authorization at any time by sending a written notice to the facility provider releasing records. A revocation is not valid if action was previously taken in reliance on this authorization.

_____ _____/_____/_____

Individual or Parent/Legal Guardian Signature Date Signed

_____

Printed Name of Person signing

I have _____ accepted _____ declined a copy of this Releases of Information. _____initial

Date copy of this form sent to Individual and/or Parent/Legal Guardian: _____/_____/_____