

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: Specialty Physician

Release information To:

Table with 4 rows and 2 columns. Columns: Name / Agency, Address, City/State/Zip, Phone # / Fax #. Row 1: Hills & Dales. Row 2: 1011 Davis Street. Row 3: Dubuque, IA 52001. Row 4: 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 (X) 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.

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.

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: / /