SOUTHEAST IOWA LINK
MENTAL HEALTH DISABILITY SERVICES
Authorization to Obtain and/or Disclose Information

Individual Name:	**SSN:**	**DOB:**

"I hereby authorize the county MHDS staff to obtain and/or disclose oral and/or written information that has been indicated below with the following individual(s) and/or agency(s):"

Address of agency/individual listed above:	**Phone & Fax #'s of agency/individual listed above:**

THIS INFORMATION WILL BE OBTAINED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSE:

☐ Coordination of Services ☐ Service Planning ☐ Determining Eligibility for Funding

☐ Monitoring of Services ☐ Assessment Purposes ☐ Other_____

INFORMATION TO BE OBTAINED AND/OR DISCLOSED:

☐ Funding and/or Eligibility _____
☐ Evaluation/Assessment_____
☐ Educational and/or Vocational Assessment
☐ Family and/or Social Data
☐ Physical/Mental Status_____
☐ Agency(s) and/or Individual(s) participation, annual plans & reviews, social history, progress reporting, discharge summaries, service planning (if applicable)
☐ Financial Information _____
☐ Other _____
☐ Other

SPECIFIC AUTHORIZATION TO OBTAIN AND/OR DISCLOSE INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

"I specifically authorize county MHDS staff to obtain and/or disclose data or information relating to the following:"

(Please check and initial appropriate boxes)

☐ Mental Health ☐ (initial) ☐ Substance Abuse ☐ (initial) ☐ HIV-AIDS ☐ (initial)

Authorizing Signature	**Date**	**Relationship to Applicant (if applicable):**

AFFIRMATION OF AUTHORIZATION: "I give the above named agency permission to obtain and/or disclose the information that I have selected on this form with the individual(s) and/or agency(s) that have been listed and only for the purpose selected. This authorization is valid up to one year unless specified below. I understand that I may revoke this authorization at any time. The revocation will take effect on the date it is received in writing. As a client, I have the right to access my treatment or other records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost (see staff for details). I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described may be re-disclosed and no longer protected by the regulations."

This authorization is valid up to one year unless otherwise specified or noted: _____

Authorizing Signature	**Date**	**Relationship to Applicant (if applicable)**

Please send requested information or direct questions to:

Washington County Mental Health
Disability Services
P.O. Box 902
2175 Lexington Blvd. Bldg. #2
Washington, IA 52353
PHONE: 319-653-7751
FAX: 319-653-7755

Please indicate below if you would like a copy of this Authorization. If you <u>do not</u> indicate either, you will not be given a copy unless you request one verbally.

I request a copy of this Authorization: ☐
I decline a copy of this Authorization: ☐