Champion State of Mind

Mental Health Solutions Focused on You

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Authorization to Release Confidential Information

Client DOB/Effective Date: ____________________

A. Client Information:

Name: ____________________

Address: ____________________

Phone: ____________________ Birthdate: ____________________ Social Security #: ____________________

Parent/guardian (if applicable): ____________________

Address and phone of parent/guardian: ____________________

____

B. Release to Whom (Name of Person and/or Facility): ____________________

____

Address: ____________________ City, State: ____________________

Zip Code: ____________________ Phone: ____________________ Fax: ____________________

C. Purpose of Disclosure *(mark all that apply)*

❑ Coordination ❑ Personal ❑ Legal ❑ Healthcare ❑ Referral ❑ Billing

Other: ____________________

D. I hereby authorize Champion State of Mind, PLLC and the source named above (Section B) to each exchange, disclosure, send and/or obtain the records listed which are marked/indicated in the boxes below:

- ❑ All records (full records disclosure)
- ❑ Treatment/service plans and recovery plans
- ❑ Admission and discharge summaries
- ❑ Billing records
- ❑ Social histories, assessments with diagnoses
- ❑ Medical histories, assessments with diagnoses
- ❑ Progress reports
- ❑ Physical examination(s) report
- ❑ Workshop reports and other vocational evaluations
- ❑ Academic or educational records
- ❑ Date and times of appointments
- ❑ Urinalysis and/or Oral Fluid testing results
- ❑ Evaluation(s), reports, or treatment summary of progress
- ❑ Information required to perform Urinalysis and/or Oral Fluid collection and labeling of the collected specimen
- ❑ A letter containing dates of treatment(s) and summary of care/treatment
- ❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, emotional illness or drug and/or alcohol abuse
- ❑ Other: ____________________

This is strictly confidential client medical information. Re-disclosure or transfer of this information and form is expressly prohibited by law.

E. I authorize all Champion State of Mind, PLLC providers, staff and associates, unless otherwise limited to: ________________ ____, to speak in written or verbal communication with the source named above about the reasons for my/the client's referral, any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

F. I authorize the source named above to speak in written or verbal communication with all Champion State of Mind, PLLC providers, staff and associates, unless otherwise limited to: ____, about the reasons for my/the client's referral, any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

G. The information authorized for release may include protected health information related to mental health, substance or drug use, genetic testing and/or HIV-related information. Release of such records or psychotherapy notes require consent of the treating provider or a court order. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.

H.I understand that a "treating provider relationship" exists when a client receives, agrees to receive, or is legally required to receive diagnosis, evaluation, treatment, or consultation, for any condition, from an individual or entity who undertakes or agrees to undertake that diagnosis, evaluation, treatment, or consultation. An in-person encounter is not required.

I. I understand that no service, treatment, eligibility or payment will be denied to me/the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. The information disclosed may be used in connection with my/the client's treatment. I understand, however, that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state or federal law.

J. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursu-ant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Client's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Pre-vention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), federal and state law of chapter 228 of Iowa code , which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

K.I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder client records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

L. The potential for information disclosed pursuant to the Authorization to may be subject to re-disclosure by the recipient and no longer be protected by federal law. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

M. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written notification to Champion State of Mind, PLLC revoking the authorization and transfer of information, but that this revocation is not retroactive. CFR Part 2 does permit me to revoke consent orally [42 CFR §2.31(a)(8),(c)(8)] regarding drug and alcohol related information until proper written notification can be obtained**.** If I do not void this request/authorization, it will automatically expire one (1) year from the signed date, unless otherwise specified: ____
(date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent)

N. I agree that a photocopy and/ or fax of this form is acceptable and is to be considered as valid as the original, but it must be individually signed by me, the releaser, and a witness if necessary. I agree that an electronic signature is acceptable and is to be considered as valid as an original signature.

O. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request and to receive a list of all entities that have received my information under a signed general designation.

In compliance with 42 C.F.R. Part 2 (Public Law 93-282), federal law, and state law Chapter 228 of Iowa code, specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations, is required for the release of HIV-related information, genetic information, mental health and drug and alcohol information. Unauthorized disclosure may result in criminal and/or civil penalties.

I specifically authorize HIV-related information, genetic information, mental health and drug and alcohol information contained in these records will be released under this consent indicated here: (mark all that apply)

- ❑ **Do release MENTAL HEALTH INFORMATION**
- ❑ **Do release DRUG AND ALCOHOL INFORMATION**
- ❑ **Do release HIV-RELATED INFORMATION**
- ❑ **Do release GENETIC INFORMATION**

Other: ____

Signature of client	Printed name	Date	
Signature of parent/guardian/representative	**Printed name**	**Relationship**	**Date**

Signatures:

Signature of client	Printed name	Date	
Signature of parent/guardian/representative	**Printed name**	**Relationship**	**Date**

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent but was physically unable to provide a signature (if applicable).

Signature of witness **Printed name** **Date**

I, a professional and/or staff member, have discussed the issues above with the client and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent (if applicable).

Signature of professional and/or staff member **Printed name** **Date**

❑ Copy for client or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records

This is strictly confidential client medical information. Re-disclosure or transfer of this information and form is expressly prohibited by law.