Mental Health/Disability Services of the East Central Region
Application Checklist

What do I include with my application?

- Completed and signed application, including the last page regarding Notice of Privacy Practice.
- The last two months of bank statements you received
- Copies of paystubs or proof of income for the last two months for you and all members of your household (*defined as the following: for an individual who is 18 years of age or over, the individual, the individual's spouse or domestic partner, and any children, step-children, or wards under the age of 18 who reside with the individual).*
- A copy of your State issued photo ID. This may include a driver's license or identity card. If you are not a citizen of the United States you will need to submit a copy of your visa or green card.
- A signed Release of Information for each agency for which you would like funding and any other agency or person you would like us to be able to get information from or give information to.
    - Please fill in your name and demographic information as well as the provider/individual's name and address.
    - You must use a separate release for each individual/provider. If you need additional releases, please make copies of the release or request releases from one of the county offices listed below.
    - Make sure you sign the release above first dark line. If you would like substance abuse or information regarding AIDS released, please check the applicable box and sign this section also.
    - Please do not sign a blank Release of Information since it cannot be used.
- A signed Copy of the "Authorization for the Use or Disclosure of Confidential Information" (ISAC Multi-Party ROI) form so the region can obtain or release information with other regions and counties if needed to determine eligibility or approve services.
- A copy of your insurance card if you have insurance.

The application is sufficient for outpatient mental health services. Other services require proof of a qualifying diagnosis and an assessment of needs (see MHDS of ECR Management Plan). You will be asked to provide this information or sign a release for the provider who can supply the information.

What are some hints to make sure my application is complete?

- Please remember to write down the services you are requesting and the provider you wish to use. If you do not know who you want for a provider, call your county office and ask for help. The number of your county office is listed at the bottom of this letter.
- Please do not leave questions blank. If they are not applicable (N/A) or $0, please indicate this.
- List all income, before taxes that was received by you or your significant other. This would include child support, alimony, disability benefits, unemployment insurance or other benefits. Do not include employment income for minors.
- List child support that you or your significant other pay and provide documentation of the payment for the past two months.
- Be sure to list the name of any medical insurance company and policy number that you may have, including Medicare and Medicaid/Title 19.

Where do I send my application when it is complete?

- E-mail: intake@ecriowa.us (please send via secure e-mail)
- Fax: 319-892-5679
- Mail: MHDS of the ECR
  1240 26th Ave Court SW
  Cedar Rapids, IA 52404

MH/DS of the East Central Region Application Form

For individuals living in: Benton, Bremer, Buchanan, Delaware, Dubuque, Iowa, Johnson, Jones, and Linn

Application Date: _____ **Date Received by Office:** _____

First Name: _____ **Last Name:** _____ **MI:** _____

Nickname: _____ **Maiden Name:** _____

Date of Birth: _____ SSN**#**_____ **E-Mail Address**_____

Race: ☐ American Indian ☐Asian/Pacific Islander ☐Black/African American ☐Other _____ ☐ Unknown ☐White

Sex: ☐Male ☐Female **US Citizen:** ☐Yes ☐No **If you are not a citizen, are you in the country legally?** ☐Yes ☐No

Marital Status: ☐Single ☐ Married ☐Divorced ☐Separated ☐Widowed **Primary Language:** _____

Legal Status: ☐**Voluntary** ☐**Involuntary-Civil** ☐**Involuntary-Criminal** ☐**Probation** ☐**Parole** ☐**Jail/Prison**

Are you considered legally blind? ☐Yes ☐No If yes, when was this determined? _____

Home Phone: _____ **Cell:** _____ **May we leave a message?** ☐Yes ☐No

Current Address: _____

Street City State Zip County

Begin Date at this address: _____

☐**Use as current Mailing Address:** If not list address _____

Previous Address_____

Street City State Zip County

Begin Date_____ **End Date**_____

Living Arrangement: ☐ Alone ☐ With family members ☐ With unrelated individuals **Number of roommates:** _____

Current Residential Arrangement: ☐Private Residence ☐Foster Care/Family Life Home ☐Correctional Facility

☐Homeless/Shelter/Street ☐ Residential Facility, type: _____ ☐ Other: _____

Veteran Status: ☐Yes ☐No **Branch & Type of Discharge:** _____ **Dates of Service:** _____

Current Employment: (Check applicable employment)

☐Unemployed, available for work	☐Unemployed, unavailable for work	☐Employed, Full time
☐Employed, Part time	☐Retired	☐Student
☐Work Activity	☐Sheltered Work Employment	☐Supported Employment
☐Vocational Rehabilitation	☐Seasonally Employed	☐Armed Forces
☐Homemaker	☐ Volunteer	☐Other _____

Current Employer: _____ **Position:** _____

Dates of employment: _____ **Hourly Wage:** _____ **Hours worked weekly:** _____

Employment History: (list starting with most recent to previous)

Employer	City, State	Job Title	Duties	To/From
1.				
2.				

Education: What is the highest level of education you achieved? # of years: _____ Degree/GED: _____

Emergency Contact Person:

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Current Service Providers: _____

Application continues on the back of this page

Guardian/Conservator appointed by the Court? ☐Yes ☐No **Protective Payee Appointed by Social Security?** ☐Yes ☐No

☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
(Please check those that apply & write in name, address, etc.)

Name: _____

Address: _____

Phone: _____

☐**Legal Guardian** ☐**Conservator** ☐**Protective Payee**
(Please check those that apply & write in name, address, etc.)

Name: _____

Address: _____

Phone: _____

List All People In Household:

Name	Age	Relationship	Social Security Number
1.			
2.			
3.			
4.			
5.			

INCOME: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.
If you have reported no income below, how do you pay your bills? (Do not leave blank if no income is reported!)

_____

_____

Gross Monthly Income (before taxes**):**	**Applicant Amount:**	**Others in Household Amount:**
☐ Employment Wages		
☐ Social Security		
☐ SSI		
☐ SSDI		
☐ Veteran's Benefits		
☐ Child Support		
☐ FIP		
☐ Pension		
☐ Public Assistance/General Assistance		
☐ Workers Comp		
☐ Private Relief Agency		
☐ Family/Friends		
☐ Other: _____		
Total Monthly Income:		

Household Resources: (Check and fill in amount and location):

Type	**Amount**	**Bank, Trustee, or Company**
☐ Trust Funds		
☐ Dividend Interest		
☐ Stocks/Bonds		
☐ CD's		
☐ Burial Fund/Life Ins. (cash value)		
☐ Cash		
☐ Checking		
☐ Saving		
☐ Retirement Fund (non-accruing)		
☐ Other _____		
Total Resources:		

Do you pay any of the following (please indicate amount per month): ☐Child Support_____ ☐ Alimony_____

Application continues on next page

Motor Vehicles: ☐Yes ☐No Make & Year: _____ Estimated value: _____
(include car, truck, motorcycle, boat, Make & Year: _____ Estimated value: _____
recreational vehicle, etc.) Make & Year: _____ Estimated value: _____

Do you, your spouse or dependent children own or have interest in the following:
House including the one you live in? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____ ☐Yes ☐No
If yes to any of the above, please explain: _____

Have you sold or given away any property in the last five (5) years? ☐Yes ☐No **If yes, what did you sell or give away?**
_____

Health Insurance Information: (Check all that apply)

Primary Carrier (pays 1st)

☐**Applicant Pays** ☐**Medicaid** ☐**Family Planning only**
☐**Medicare A, B, D** ☐**Medically Needy**
☐**No Insurance** ☐ **Private Insurance**
Company Name _____
Address _____
_____
Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ **Any limits?** ☐ **Yes** ☐ **No**
Spend down: _____ **Deductible:** _____

Secondary Carrier (pays 2nd)

☐**Applicant Pays** ☐**Medicaid** ☐ **Family Planning only**
☐**Medicare A, B, D** ☐ **Medically Needy**
☐**No Insurance** ☐**Private Insurance**
Company Name _____
Address _____
_____
Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ **Any limits?** ☐ **Yes** ☐ **No**
Spend down: _____ **Deductible:** _____

Referral Source: ☐**Self** ☐**Community Corrections** ☐**Family/Friend** ☐**Social Service Agency** ☐**Targeted Case Management**
☐**Other Case Management** ☐**Other** _____

Have you applied for any of the public programs listed below?
(Please check those you have applied for and the status of your referral) Has your application been Approved or Denied? If denied and you appealed, what is the date of appeal _____ Have you applied for reconsideration_____. Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing: _____

☐Social Security_____ ☐SSDI/SSI_____ ☐Medicare_____
☐Medicaid_____ ☐DHS Food Assistance: _____ ☐FIP _____
☐Veterans _____ ☐Unemployment_____ ☐Other_____

Disability Group/Primary Diagnosis: (If known)
☐Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury
Specific Diagnosis determined by:_____ Date:_____
Axis I: _____ Dx Code(s): _____
Axis II:_____ Dx Code(s): _____
Why are you here today? What services do you <u>NEED</u>? (this section <u>must</u> be completed as part of this application!)
_____
_____

I certify that the above information is true and complete to the best of my knowledge, and I authorize ECR staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Department of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the East Central Region in establishing my ability to pay for services requested, and in assuring the appropriateness of services requested. I understand that information in this document will remain confidential.

_____
Applicant's Signature (or Legal Guardian) **Date**

_____
Signature of other completing form if not Applicant or Legal Guardian **Date**

<u>Please read and sign the Privacy Policy located on the back of this page</u>.

MH/DS OF THE EAST CENTRAL REGION
ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICE

I,_____, do hereby acknowledge receipt of a copy of the Mental Health and Disability Services of the East Central Region's Notice of Privacy Practice, Policy and Procedure.

_____ _____
Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE (guardian, power of attorney, etc.)

_____ _____
Signature of personal representative Date

_____ _____
Legal authority of personal representative Date

OR

IF YOU DO NOT WANT A COPY OF THE REGION'S PRIVACY PRACTICE

I, _____, do hereby acknowledge that I was informed of the Mental Health and Disability Services of the East Central Region' s Notice of Privacy Practice, Policy and Procedure and was offered a copy of the Notice of Privacy Practice, Policy and Procedure but have declined the receipt of the Notice.

_____ _____
Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE (guardian, power of attorney, etc.)

_____ _____
Signature of personal representative Date

_____ _____
Legal authority of personal representative Date

MHDS OF THE EAST CENTRAL REGION

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect July 1, 2014, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our active clients at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose protected health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your protected health information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use or disclose your protected health information to pay claims from providers, hospitals, or for other services delivered to you that are covered by MHDS of the East Central Region, to determine your eligibility for services, to coordinate your services, to issue explanations of benefits and the like. We may disclose your information to a health care or service provider subject to the federal Privacy Rules so they can engage in billing/payment activity.

Operations: We may use and disclose your information in connection with our operations. Our operations include:

- rating our risk;
- quality assessment and improvement activities
- reviewing the competence or qualifications of mental health/disability services professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- business planning and development; and
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified information or a limited data set.

We may disclose your information to another entity which has a relationship with you and is subject to the federal Privacy Rules, for their operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care and service professionals, or detecting or preventing fraud and abuse.

On Your Authorization: You may give us written authorization to use your protected health information or to disclose to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. To the extent that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. In

information for marketing purposes and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we will not use or disclose your protected health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your services. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before we disclose your protected health information to a person involved in your care, services or payment for services, we will provide you with an opportunity to object to such uses or disclosures, If you are not present, or in the event of your incapacity or an emergency, we will disclose your protected health information based on our professional judgment of whether the disclosure would be in your best interest.

Disaster Relief: We may use or disclose your protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

addition, most uses and disclosures of protected health

Public Benefit: We may use or disclose your protected health information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Individual Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. This may include an electronic copy in certain circumstances. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.25 for each page, $12.00 per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or locations and continues to allow us to conduct normal business operations.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Breach Notification: In the event of a breach of your unsecured protected health information, we will provide you notification of such a breach, as required by law.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jan Heidemann
Telephone: (319) 352-2993
Email: jheidemann@co.bremer.ia.us
Fax: (319) 352-2997
Address: Bremer County Annex
203 1st Avenue NE
Waverly, IA 50677

MENTAL HEALTH/DISABILITY SERVICES

OF THE
EAST CENTRAL REGION

RELEASE OF INFORMATION

INDIVIDUAL'S FULL NAME _____ DATE OF BIRTH _____
SOCIAL SECURITY NUMBER XXX-XX-____ STATE ID # _____

ADDRESS OF INDIVIDUAL USING SERVICES _____

I, the undersigned, hereby authorize MH/DS East Central Region staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named individual using services, with:

_____
Name of Person or Agency

_____
Complete Mailing Address

The information being released will be used for the following purpose:

- ☐ Planning and implementation of my Individual Comprehensive Plan
- ☐ Coordination of Services
- ☐ Monitoring of Services
- ☐ Referral for new services
- ☐ Other (specify) _____

INFORMATION TO BE RELEASED OR OBTAINED:

Yes	No		Yes	No	
☐	☐	Medical/Health/Dental	☐	☐	Financial/Insurance
☐	☐	Hospital (specify dates) _____	☐	☐	Assessment
☐	☐	Psychiatric	☐	☐	Social History
☐	☐	Psychological	☐	☐	Service/Treatment Plans
☐	☐	Educational	☐	☐	Progress Reporting
☐	☐	Vocational	☐	☐	Re-Release of 3rd Party Info (specify) _____
☐	☐	Legal	☐	☐	Other (specify) _____

No express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to MH/DS East Central Region, Attn: Intake Coordinator, 105 Broadway Place, Suite 2, PO Box 427, Anamosa, IA 52205. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the office listed above.

I understand that I can refuse to sign this authorization but failure to provide access to information necessary to determine eligibility for funding of services may be a basis for denial of service funding. This authorization will expire one year after the date it is signed, unless revoked, or as specified: (list specific event, date or condition) _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I specifically authorize the release of data and information relating to Mental Health:

_____
Signature of individual, parent (if minor), or legal guardian Date

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SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:
I specifically authorize the release of data and information relating to: (in order for this information to be released, you must sign here and above)

☐ **Substance Abuse** (to be signed only by the Individual Using Services) ☐ **HIV-Related Information**

_____ _____
Signature of Individual Using Services Date Legal Guardian Signature Date

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Copies: Date: _____ Individual/Guardian Agency File

PATIENT BILL OF RIGHTS

Sharing Your Medical Information with Other Iowa Counties and Regions to Improve Your Care

Purpose of Letter

The purpose of this letter is to provide you with information about the reason sharing your medical information is necessary. You have an option to not sign this medical information release but doing so may prevent us from having a complete picture of your complete health.

Iowa Law

Iowa's Disclosure of Mental Health and Psychological Information, Chemical Substance Abuse, and Acquired Immune Deficiency Syndrome (AIDS) laws provide protection of your mental health, chemical and substance abuse history, and AIDS testing information. The law is very restrictive on who may see your mental health, chemical and substance abuse history, and AIDS testing information. If you receive services from multiple counties, Iowa Law prevents the counties from sharing this health information.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) provides federal protection for individually identifiable health information. However, the rule also allows entities to disclose health information needed for patient care and other purposes, like the ability to bill for the care provided to you.

The Iowa laws protecting mental health, chemical and substance abuse history, and AIDS testing information were passed before HIPAA. Iowa law is more protective than HIPAA and it prevents providers and other health care entities from sharing necessary information to provide you complete care.

Sharing Your Mental Health, Chemical and Substance Abuse History, and AIDS Testing Information Helps Iowa Counties Have a More Complete Picture of Your Health

By signing this agreement you are allowing Iowa counties and regions to share your mental health, chemical and substance abuse history, and AIDS testing information in order to provide better care for you. We do have important safeguards in place to make sure all of your mental health, chemical and substance abuse history, and AIDS testing information is safe. Only authorized individuals will have access to your information. Nothing in this release allows improper use of your mental health, chemical and substance abuse history, and AIDS testing information.

You Can Choose Not to Sign This Agreement

Your privacy is important to us, so we will respect your choice on whether you want us to share your mental health, chemical and substance abuse history, and AIDS testing information with other Iowa counties and regions. You have the right to revoke this authorization at any time.

You May Request a Copy of Your Record

You may request a copy of your CSN record at any time, except for psychological test materials and psychotherapy notes. This includes a list of disclosures of your CSN record. The county or region may impose a reasonable, cost-based fee. That fee may consist of labor for copying your CSN record, supplies for making the copy (such as paper and ink), postage to mail your CSN record to you, and preparing an explanation or summary of your medical information.

Questions

If you have questions or concerns about this agreement, you can bring it up next time you're receiving care from your county. Questions should be directed to your county or region's Privacy Officer.

Authorization for the Use or Disclosure of Confidential Information
MENTAL HEALTH/DISABILITY SERVICES OF THE EAST CENTRAL REGION
NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 125, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.

AUTHORIZATION SECTION

Client Name: _____ Date of Birth: _____ Client #: _____
Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and with Polk County Health Services (a list of the current affiliated case management entities and other providers is available upon request), with the exception of the following Iowa counties, Regions or other entities: _____.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

Information to be disclosed includes:	**For the following purposes:**
Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance described in Iowa Code § 252.25.	Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations and abiding by state and federal reporting requirements.

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

I hereby specifically authorize the release and sharing of information relating to: (check and sign any that apply)

☐ HIV/AIDS Related Testing Information

X_____
Client signature required

☐Mental Health Information (**NOTE**: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information).

X_____
Client signature required

☐ Chemical Dependency (Drug/Alcohol) Treatment Information. (Note: In addition to the individuals and organizations identified by name or title in this Authorization, I specifically authorize the release of drug or alcohol abuse patient information to the following individuals or organizations (by name or title)):

_____

_____

X_____
Client signature required

Concerning the care of the above client from (select one):

☐ Any and all dates; or

☐ Dates _____/____/_____to _____/____/_____.

Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:

☐ _____/____/_____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.

Signed: _____ Date:_____

Print Name: _____ Telephone:____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client ☐ personal representative of deceased client

☐ guardian or conservator of a client (if and to the extent authorized under State law) ☐ other (specify) _____

REVOCATION SECTION

I hereby revoke this Authorization.

Signed: _____ Date:_____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE

Notice to Recipients of Mental Health Information: In accordance with Iowa Code Chapter 228, a recipient of mental health information may further disclose this information *only* with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Notice to Recipients of Substance Abuse Treatment Information: This information may have been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2), and Iowa Code Chapter 125. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Notice to Recipients of HIV-Related Testing Information: This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code § 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

Iowa Counties:			Iowa Mental Health and Disability Services Regions:
Adair	Floyd	Monroe	Central Iowa Community Services
Adams	Franklin	Montgomery	County Rural Offices of Social Services
Allamakee	Fremont	Muscatine	County Social Services
Appanoose	Greene	O'Brien	Eastern Iowa MHDS
Audubon	Grundy	Osceola	Heart of Iowa
Benton	Guthrie	Page	MHDS of the East Central Region
Black Hawk	Hamilton	Palo Alto	Mid Iowa
Boone	Hancock	Plymouth	North West Iowa Care Connection
Bremer	Hardin	Pocahontas	Rolling Hills Community Services
Buchanan	Harrison	Polk	Sioux Rivers MHDS
Buena Vista	Henry	Pottawattamie	South Central Behavioral Health
Butler	Howard	Poweshiek	Southeast Iowa Link
Calhoun	Humboldt	Ringgold	Southern Hills Regional Mental Health
Carroll	Ida	Sac	Southwest Iowa MHDS
Cass	Iowa	Scott	
Cedar	Jackson	Shelby	
Cerro Gordo	Jasper	Sioux	
Cherokee	Jefferson	Story	
Chickasaw	Johnson	Tama	
Clarke	Jones	Taylor	
Clay	Keokuk	Union	
Clayton	Kossuth	Van Buren	
Clinton	Lee	Wapello	
Crawford	Linn	Warren	
Dallas	Louisa	Washington	
Davis	Lucas	Wayne	
Decatur	Lyon	Webster	
Delaware	Madison	Winnebago	
Des Moines	Mahaska	Winneshiek	
Dickinson	Marion	Woodbury	
Dubuque	Marshall	Worth	
Emmet	Mills	Wright	
Fayette	Mitchell		
	Monona		

Copy sent to Client/Guardian on: _____ (date) at following address: _____