

RELEASE OF INFORMATION

LOUISA COUNTY COMMUNITY SERVICES (Central Point of Coordination/Case Management) 407 Washington St. Wapello, IA 52653

CONSUMER:

MEMBER # :

CONSUMER ADDRESS:

I, the undersigned, hereby authorize Louisa County Community Services staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named consumer, 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 FROM LOUISA COUNTY COMMUNITY SERVICES:

- SOCIAL HISTORY
PROGRESS SUMMARY REPORT
INDIVIDUAL COMPREHENSIVE PLAN
ANNUAL REVIEW
DISCHARGE SUMMARY
RE-RELEASE OF 3RD PARTY INFO (specify)
OTHER (specify)
OTHER (specify)

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

- SOCIAL HISTORY
EDUCATIONAL/VOCATIONAL PLANS
PROGRESS SUMMARY
PSYCHOLOGICAL EVALUATIONS/REPORTS
PSYCHIATRICASSESSMENT/REPORTS
MEDICAL HISTORY
TREATMENT PLAN
DISCHARGE SUMMARY
RE-RELEASE OF 3RD PARTY INFO (specify)
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 Louisa County Community Services. 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 recipient named, or Louisa County Community Services.

I understand that I can refuse to sign this authorization, but failure to provide access to information necessary for the funding and implementation of services may be a basis for denial of services.

This authorization shall expire on: (not to exceed 12 calendar months from date of signature, unless revoked or as specified - list specific event, date or condition).

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

Signature of Consumer or Legal Guardian: Date

Relationship if Not The Consumer

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

(In order for this information to be released, you must sign here and above)

I specifically authorize the release of data and information relating to (check all that apply):

Substance Abuse (must be signed by the consumer)

HIV-Related Information

Consumer Signature Date

Guardian Signature Date

Date copy given to Consumer