

**Insert AAA Name**  
**Authorization to Obtain or Release Health Care Information**

Consumer Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Guardian/Agent (Health Care Power of Attorney): \_\_\_\_\_

**I authorize the following individual or agency to share written and oral information (*two-way or reciprocal release*) about my needs and the services I receive**

Name or agency to release and receive information: Insert AAA Name

Address:

City/State/Zip:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**With the following individual or agency:**

Name or agency to release and receive information:

Address:

City/State/Zip:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

***The information released or shared may include:***

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Admission status   | <input type="checkbox"/> Face sheet              | <input type="checkbox"/> Social history                |
| <input type="checkbox"/> Assessments  | <input type="checkbox"/> Family data photos      | <input type="checkbox"/> Team notes                    |
| <input type="checkbox"/> Consultation reports include<br>(doctor/specialty name): | <input type="checkbox"/> History & physical exam | <input type="checkbox"/> Treatment and aftercare plans |
| <input type="checkbox"/> Court documents  | <input type="checkbox"/> Immunization record     | <input type="checkbox"/> X-ray/imaging reports         |
| <input type="checkbox"/> Diagnosis/allergies                                      | <input type="checkbox"/> Lab results             | <input type="checkbox"/> Other (please specify):       |
| <input type="checkbox"/> Discharge summary  | <input type="checkbox"/> Medication history      | Other (note exceptions or limits to<br>this release):  |
| <input type="checkbox"/> Evaluation &<br>recommendations                          | <input type="checkbox"/> Psychological reports   |  |
|   | <input type="checkbox"/> Receiving phone calls   |  |
|   | <input type="checkbox"/> School records          |  |

**This information is being used ONLY for (state purpose): Assessment, service and intervention planning, advocacy and access to products and/or services.**

**Specific Authorization for Release**

**Type of Information**

**Authorizing initials**

I authorize the release of the information listed at the right, which requires specific consent under federal law:

- Mental Health evaluation/treatment\*
- AIDS/HIV – related
- Substance Abuse\*\*

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time, orally or in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire one-year after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact: AAA/Service Provider Name at AAA/Service Provider's Telephone number. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing Signature:	Date:	Expiration Date:
Relationship to client: <input type="checkbox"/> Self <input type="checkbox"/> Legal Representative <input type="checkbox"/> Nearest Living Relative <input type="checkbox"/> Other (specify below)		
<input type="checkbox"/> Not Required  <input type="checkbox"/> Required	Witness Signature: <hr/> Witness Signature:	

**Record of Disclosures**  
(Required for mental health information)

Client Name:
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Date	Name of Recipient	Contents Disclosed	Sent By
1.			
2.			
3.			
4.			
5.			

\* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.  
 \*\* Only the consumer can authorize release of substance abuse information unless the consumer is of such age and mental maturity that they are unable to authorize release.

**Notice to Recipients of Mental Health Information**

In accordance with “Disclosure of Mental Health and Psychological Information” (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the consumer the consumer’s legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Notice to Recipients of Substance Abuse Information**

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. 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 has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity**

It is the policy of Insert AAA Name Area Agency on Aging to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status. If you believe you may have been treated unfairly in the areas of employment or accommodations please contact in writing or call:

Privacy Officer  
Insert AAA Name  
Mailing Address  
Phone Number  
-OR-

Iowa Civil Rights Commission  
Grimes State Office Building  
400 E. 14th Street  
Des Moines, IA 50319  
515-281-4121 or 800-457-4416

*A photocopy of this signed authorization shall have the same force and effect as this original.*