Authorization for Release of Health Information

Psychiatric Associates
673 Westbury Drive, Suite 201
Iowa City, IA 52245
Phone: (319) 356-6352 Fax: (319)358-2367

Patient Name: **Date of Birth:** **Social Security Number:**

Patient Address:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this forth with full knowledge that this Authorization expires one year from the date the Authorization is signed or upon the minor's age of majority:

In accordance with Iowa State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at anytime by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **Name and address of health provider or entity to release this information:**

   _____

   _____

7. **Name and address of person(s) or category of person to whom this information will be sent:**

   _____

   _____

8. **Specific information to be released**:
   - o Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
   - o Other: _____
   - o Include: (Indicate by Initialing)

     _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ **HIV-Related Information**

9. **If not the patient, name of person signing form:**

   _____

10. **Authority to sign on behalf of patient:**

    _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ **Date:** _____

Signature of patient or representative authorized by law.