

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Unemployed, available for work | <input type="checkbox"/> Unemployed, unavailable for work | <input type="checkbox"/> Employed, Full time |
| <input type="checkbox"/> Employed, Part time | <input type="checkbox"/> Retired | <input type="checkbox"/> Student |
| <input type="checkbox"/> Work Activity | <input type="checkbox"/> Sheltered Work Employment | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Vocational Rehabilitation | <input type="checkbox"/> Seasonally Employed | <input type="checkbox"/> Armed Forces |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Volunteer | <input type="checkbox"/> 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 |
|---|--------|
| <input type="checkbox"/> Trust Funds | _____ |
| <input type="checkbox"/> Dividend Interest | _____ |
| <input type="checkbox"/> Stocks/Bonds | _____ |
| <input type="checkbox"/> CD's | _____ |
| <input type="checkbox"/> Burial Fund/Life Ins. (cash value) | _____ |
| <input type="checkbox"/> Cash | _____ |
| <input type="checkbox"/> Checking | _____ |
| <input type="checkbox"/> Saving | _____ |
| <input type="checkbox"/> Retirement Fund (non-accruing) | _____ |
| <input type="checkbox"/> Other _____ | _____ |
- Total Resources: _____

Bank, Trustee, or Company

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 NEED? (this section must 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 _____

Please read and sign the Privacy Policy located on the back of this page.

**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.

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.

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

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

addition, most uses and disclosures of protected health

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.

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

Email: jheidemann@co.bremer.ia.us

Telephone: (319) 352-2993

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

 Phone Fax

- 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 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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, 210 5th Ave NE, Independence, IA 50644. 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

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

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

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

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)

- | | | |
|---|--|--|
| <input type="checkbox"/> HIV/AIDS Related Testing Information | <input type="checkbox"/> 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). | <input type="checkbox"/> Chemical Dependency (Drug/Alcohol) Treatment Information. (NOTE: Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed.) |
|---|--|--|

X _____
 Client initials required

X _____
 Client initials required

X _____
 Client initials required

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:

- | | |
|--|---|
| <input type="checkbox"/> parent or guardian of minor client | <input type="checkbox"/> personal representative of deceased client |
| <input type="checkbox"/> guardian or conservator of a client (if and to the extent authorized under State law) | <input type="checkbox"/> other (specify) _____ |

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

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 whose confidentiality is protected by Iowa Code Chapter 125. Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed.

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 Chapter 141A apply to the unauthorized disclosure of these records.

EXHIBIT A

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

REVOCACTION SECTION

I hereby revoke this Authorization.

Signed: _____

Date: _____