Cedar Centre Psychiatric Group

1730 1st Ave NE, Cedar Rapids, IA 52402-5433 *Phone # 319-365-3993*
PO Box 1408, Cedar Rapids, IA 52406-1408 *Fax # 319-364-0116*

AUTHORIZATION TO RELEASE INFORMATION

I. AUTHORIZATION FOR RELEASE OF INFORMATION AND REDISCLOSURE

I hearby authorize Cedar Centre Psychiatric Group

To Disclose the following information from the health records of *[patient name]:*

Name:_____

Last First MI Birth Date

This information is to be _____Exchanged with _____Disclosed to _____Obtain From

Name:_____
[name of entity/address]

Address:_____

SPECIFIC RECORDS AUTHORIZED FOR RELEASE: __Discharge Summary __Diagnosis/Client History __Labs

__Progress Notes __Treatment Plan(s) __Assessments/Evaluations __Medications __Neurological
__Other (please specify)_____

Unless specified below under 'Limitations' this authorization includes written and verbal disclosures and electronic *interchange.* ____ **Limitations** (please specify)_____

PURPOSE OR NEED FOR THE DISCLOSURE:
___Coordination of Care ___Treatment Planning ___Diagnostic Assessment ___Management of Insurance
___Legal ___Continuing Care ___Other:_____

Affirmation of Release

I give the above name agency permission to release only the information I have selected on this form to the individual(s) or entities I have named and only for the purpose I have stated. I understand that this release is valid for one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. **Any revocation or refusal to sign this authorization will not affect my ability to obtain health care services.** The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained by me with reasonable notice and payment of copying costs. I understand that if the person or entity that receives the above specified informaiton is not a health care provider, health plan, or health clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations. I further understand that the Recipient WITHOUT FURTHER AUTHORIZATION, redisclose said information to parties and their legal counsel, insurers, reinsurers, experts, potential experts, anyone against whom a claim has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons.

II.SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(**Initia**l any category **not** to be released)

_____Mental Health _____Substance Abuse
_____HIV/AIDS _____ Genetic information including genetic test results

_____ _____
Signature of Patient/Guardian/Legal Representative Date Signed

_____ _____
Signature of Witness/Relationship to Patient Date Signed

Revised 11/21/2013