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]:*

Current Legal Name:_____
Last First MI **Birth Date**

_____
List above any other names gone by: maiden, married, legal changes, FKA or AKA

This information is to be _____Exchanged with _____Disclosed to _____Obtain From

Name: _____
[name of entity]

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.** Any revocation will take effect on the day it is received in writing in the office. As a patient I have the right to access my treatment records. I may obtain copies of my records with reasonable notice and payment of copying costs. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan, health clearinghouse covered by the federal privacy regulations or a business associate of these entities, that the information described above may be redisclosed and no longer protected by those regulations. I further understand that the Recipient WITHOUT FURTHER AUTHORIZATION, might 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. **A copy of this authorization shall be deemed the same as the original.**

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.
(Initial 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