If client is a child or has a legal guardian these must be signed by the legal guardian

1123 1st Ave E Suite 200 Newton IA 50208 Phone # 641.792.4012 Fax # 641.791.0697
200 4th Ave W Grinnell IA 50112 Phone # 641.260.8270 Fax # 641.260.8213

Patient Authorization to Release/Obtain Information
Other

Client Name ______________________________ DOB ______________ SSN ____________________

Provider/Requester: I hereby authorize Capstone Behavioral Healthcare to ☐ Release information ☐ Obtain information, verbally or in writing with the following person or institution by telephone, fax, electronic data exchange, or mail.

Name ____
Address ____
Phone Number(s)_____________________________ **fax number** ______________________

Release or obtain the following information

☐ Assessments
☐ Progress Notes
☐ Discharge Summary
☐ Psychiatric/Psychological Evaluation
☐ History & Physical
☐ Other ________________________
☐ Consultation Reports
☐ Emergency Room Report
☐ Laboratory Results
☐ Previous Admissions
☐ **All the above**

I specifically authorize the release of records that may include protected confidential information regarding
(1 and 2 need to be checked for us to be able to release **ANY** information about these items including absence of substance abuse)
☐ 1. Drug or Alcohol Abuse ☐ 2. Mental Health ☐ 3. HIV/AIDS

Expiration and Revocation This authorization will be valid for one year after the date of my signature, unless it is revoked. I understand that I may revoke this authorization by providing a written revocation to the recipient named above and to Capstone Behavioral Healthcare. I also understand that any information which has been released prior to the revocation will not be affected.

Redisclosure This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for alcohol/drug abuse records (CFR Part 2), for mental health records (Iowa Code CH228), or HIV/AIDS (Iowa Code CH, 141) federal and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.

Refusal and Conditioning of Authorization I understand that I have the right to refuse to give consent for the use of disclosure of protected information for treatment, reimbursement of health care operation and that I have the right to revoke such a consent at any time. However, except for emergency conditions, Capstone Behavioral Healthcare reserves the right to refuse treatment, refer you to another provider, or limit treatment options to you if you refuse to give your signed consent for the use of disclosure of protected information for treatment, reimbursement purposes, and/or if the services being requested are due to a court order or for the sole purpose of providing an evaluation report to a third party.

______________________________ ___________
Client Signature/Legal Guardian Date

I have requested and received a copy of this release of information ______ **(Initial)**

Witnesses by ____