PINE REST Christian Mental Health Services

The information in sections A-E (examples added in blue) is required for the release to be valid. Additional tips are included on page 2.

**AUTHORIZATION FOR RELEASE AND DISCLOSURE,
AND/OR REQUEST FOR MEDICAL INFORMATION AND RECORDS**

A.

I, Jane Doe (patient), (1/8/1968 date of birth) authorize Pine Rest Christian Mental Health Services to: (ü one or both below, or form is invalid)

✓ release information from my medical records to the individual/organization listed below

✓ request information from the individual/organization listed below

Name: John Smith

Address: Middle School, 1234 Main St., Grand Rapids, MI 49504. Ph# 555-9876

B.

For the following purpose, use or need: Coordination of care with teacher for 2013/2014 school year.

C.

The following information from my psychiatric/medical records may be disclosed, covering all dates of service or the dates from 9/1/2013 to 6/30/2014.

- ❑ Treatment Summary
- ❑ Psychiatric Evaluation
- ❑ Psychological Testing
- ❑ Physical Exam
- ❑ Laboratory Studies
- ❑ Initial Assessment
- ☑ Exchange of all written and verbal health information pertinent to the coordination of my care and treatment
- ❑ Other _____
- ❑ Exclude the following information: _____

D.

I acknowledge such information cannot be disclosed without my written informed consent unless otherwise provided by law. I agree that the information may be faxed for expediency. I have the right to revoke this authorization at any time. Any revocation will be done in writing to the attention of the Medical Records Director and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individuals listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Iowa Mental Health Code (CH.141 and 228) and also not be copied, shared or re-released, except as consistent with the authorized purpose stated above. I understand that I am not required to sign this authorization, and that Pine Rest will not refuse me treatment if I refuse to sign. I have the right to inspect and obtain a copy of the Information disclosed. A true and exact photocopy/faxed copy of this authorization shall have the same effect as the original.

I have also had the opportunity to have this form explained to me and have my questions answered.

Robert Doe	9/5/2013	Mary Jones	9/5/2013
Patient/Parent/Guardian/ Personal Representative Signature	Date	Witness Signature	Date

E.

SPECIFIC RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
Write "yes" or "no" in front of each category

yes 1. Substance Abuse (Drug/Alcohol) yes 2. Mental Health yes 3. HIV/AIDS

Robert Doe	9/5/2013
Patient/Parent/Guardian	Date

Copy of this authorization provided: Yes ✓ Declined _____

Additional Tips/Instructions For Filling Out A Release of Information Form

A

- Include the Patient's name *and* date of birth.
- One or both of these lines must be checked to indicate if Pine Rest is releasing records, requesting records, or doing both.
- The name of the person/organization that the Release of Information is being filled out for.
  —only 1 person/organization per release
  —include as much contact information as you are able to provide (address, phone number, fax number)

B

- Specify the purpose of the release. For example: Coordination of care, two-way communication, billing/scheduling, insurance/disability benefits, etc…

C

- The "from" and "to" dates are to indicate the time period of the records that are to be released.
- The first date ("from") should be a specific date.
- The second date ("to") can be a specific date or a condition/event. Some examples are:
  6/30/2014—can be a date in the future.
  5/31/2011—can be a date in the past
  Closure of current episode of care (for instances when you want the release to be valid for the entire time you are an active patient.)
- Using the term *"Present"* as your end date will equate with the date that the release was signed. For example: Services provided date range of *8/19/13* to *Present* with a release signed on 9/1/13 would mean records could be released from 8/19/13 to 9/1/13. Any records after 9/1/13 would not be able to be accessed with this release.
- At least 1 box must be ✓'d to indicate what information can be released.

D

- The **printed version** of the Iowa release does not specify a time limit on how long the release is valid (valid until revoked or case closed).
  The **Electronic Medical Record version** is valid until the case is closed unless specified otherwise. Note: this does NOT relate to the timeframe of the records that are being released or the communications that are occurring—that is covered in section C above.
- A time shorter or longer than 1 year can be specified. This can be a date *(12/31/2013)*, event or condition *(end of 2013/2014 school year* or *closure of current episode of care)*.
- If you want the release to extend for a time period after your case is closed, you could instead write *60 days after closure of current episode of care*—you can choose any # of days.
- The release must be signed/dated by the patient or a parent/guardian for a patient 17 and younger.
- The release should be witnessed by any adult who is 18 or older.

E

- The lines for Substance Use, Mental Health, HIV/AIDS must have "yes" or "no" written in them and then be signed by the patient or a parent/guardian for a patient 17 and younger.