PINE REST Christian Mental Health Services

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

I, _____ (patient), (_____ date of birth) authorize Pine Rest Christian Mental Health Services to: (✓ 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: _____

Address: _____

For the following purpose, use or need: _____

The following information from my psychiatric/medical records may be disclosed, covering all dates of service or the dates from _____ to _____.

- ❑ 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: _____

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.

_____	_____	_____	_____
Patient/Parent/Guardian/ Personal Representative Signature	Date	Witness Signature	Date

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

_____ 1. Substance Abuse (Drug/Alcohol) _____ 2. Mental Health _____3. HIV/AIDS

_____	_____
Patient/Parent/Guardian	Date

Copy of authorization provided: Yes _____ Declined _____