Passageway

6000 Grand Avenue, Suite G, Des Moines, IA 50312
Phone: 515-243-6929 | Fax: 515-243-1747 | E-mail: info@passagewayiowa.org

Authorization for Release of Information

Member: _____ DOB: _____ Medicaid #:_____

I the undersigned, hereby authorize Passageway staff to release and/or obtain the information indicated below, regarding the above named consumer, with:

_____
Name of Person or Agency

_____
Complete Mailing Address

The information being released will be used for the following purpose:

☐ Planning and implementation of my case plan
☐ Coordination of services
☐ Monitoring of services
☐ Other (specify) _____

INFORMATION TO BE RELEASED FROM PASSAGEWAY:

Yes	No	
☐	☐	Progress Summary
☐	☐	Educational/Vocational Plans
☐	☐	Program Participation Information
☐	☐	Other (specify) _____

_____

_____

INFORMATION TO BE OBTAINED FROM THE AGENCY/PERSON INDICATED ABOVE:

Yes	No	
☐	☐	Social History
☐	☐	Progress Summary Report
☐	☐	Case Plan
☐	☐	Annual Review
☐	☐	Discharge Summary
☐	☐	Psychological Evaluations/Reports
☐	☐	Psychiatric Assessments/Reports
☐	☐	Other (specify) _____

This authorization shall expire on: _____. At that time no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the recipient named and to Passageway. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the recipient named, or Passageway. **SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW: I specifically authorize the release of data and information relating to Mental Health, Substance Abuse, and/or HIV-Related Information.**

PROHIBITION ON 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 or state law for mental health records. Federal requirements (42 C.F.R. part 2) and state requirements (Iowa Code Ch. 22) prohibits further disclosure without the specific written consent of the consumer, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to either mental health or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above.

Signature of Member: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Staff Signature: _____ Date: _____