CICS
Supporting Individuals. Strengthening Communities.

www.CICSMHDS.org

RELEASE OF INFORMATION

CLIENT:_____ **STATE ID #:** _____

ADDRESS: _____ **DATE OF BIRTH:** _____

I, the undersigned, hereby authorize the staff of Central Iowa Community Services 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 services
- ☐ Coordination of services
- ☐ Monitoring of services
- ☐ Referral for new or other services
- ☐ Other (Specify) _____

Your eligibility for services or funding ☐ **is** ☐ **is not** dependent upon signing this release. {See CFR 164.508(b)(4)}

INFORMATION TO BE RELEASED FROM CENTRAL IOWA COMMUNITY SERVICES:

Yes	No	
☐	☐	SOCIAL HISTORY
☐	☐	PROGRESS SUMMARY REPORT
☐	☐	INDIVIDUAL COMPREHENSIVE PLAN
☐	☐	ANNUAL REVIEW
☐	☐	DISCHARGE SUMMARY
☐	☐	INFORMATION THAT YOU HAVE GIVEN CICS WRITTEN PERMISSION TO RECEIVE
☐	☐	OTHER (Specify) _____
☐	☐	OTHER (Specify) _____

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

Yes	No	
☐	☐	SOCIAL HISTORY
☐	☐	EDUCATIONAL/VOCATIONAL PLANS
☐	☐	PROGRESS SUMMARY
☐	☐	PSYCHOLOGICAL EVALUATION/REPORTS
☐	☐	PSYCHIATRIC ASSESSMENT/REPORTS
☐	☐	MEDICAL HISTORY
☐	☐	TREATMENT PLAN
☐	☐	DISCHARGE SUMMARY
☐	☐	FINANCIAL DOCUMENTATION
☐	☐	OTHER (Specify) _____
☐	☐	OTHER (Specify) _____
☐	☐	OTHER (Specify) _____

This authorization shall expire on: _____. If no date is listed, the release is good for one year from date of signing.

At that time, no express revocation shall be needed to terminate my consent. I understand that this consent is voluntary and I may revoke this consent at any time by sending a written notice to Central Iowa Community Services. 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 any disclosure of information carries with it the potential for un-authorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named or Central Iowa Community Services.

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.

Signature of Client or Legal Guardian: _____ **Date:** _____

_____
Relationship if NOT The Client

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAWS:
I specifically authorize the release of data and information relating to:

- ☐ Substance Abuse (must be signed by the consumer) **NOTE**: Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed.
- ☐ HIV-Related Information

Client Signature _____ **Date** _____ **Guardian Signature** _____ **Date** _____

In order for substance abuse and/or HIV-related information to be released, you must sign here and on the signature line above.
