Champion State of Mind
Mental Health Solutions Focused on You

PO Box 36
508 West Central Ave Suite B
Estherville, Iowa 51334
(P) 800-592-0180
(F) 712-566-5229
www.championmind.org

Authorization to Release Confidential Information

Client DOB/Effective Date: _____

A. Release to (Name of Person or Facility): _____

_____

Address: _____ City, State: _____

Zip Code: _____ Phone: _____ Fax:_____

B. Identifying information about the client:

Name: _____

Address: _____

Phone: _____ Birthdate: _____ Social Security #: _____

Parent/guardian (if applicable): _____

Address and phone of parent/guardian: _____

_____

C. Purpose of disclosure *(mark all that apply)*

❑ Coordination ❑ Personal ❑ Legal ❑ Healthcare ❑ Referral ❑ Billing

Other: _____

D. I hereby authorize Champion State of Mind, PLLC and the source named above (section A) to exchange, disclosure, send and/or obtain the records listed below marked by an X in the boxes below.

❑ All records (full records disclosure)
❑ Admission and discharge summaries
❑ Social histories, assessments with diagnoses
❑ Progress reports
❑ Workshop reports and other vocational evaluations
❑ Psychological evaluation(s), reports, or treatment summary of progress
❑ Treatment/service plans and recovery plans
❑ Billing records
❑ Medical histories, assessments with diagnoses
❑ Physical examination(s) report
❑ Academic or educational records
❑ Psychiatric evaluation(s), reports, or treatment summary of progress
❑ A letter containing dates of treatment(s) and summary of care/treatment
❑ Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse

❑ Other: _____

This is strictly confidential patient medical information. Re-disclosure or transfer of this information and form is expressly prohibited by law. Updated 04/2018

E. I authorize Champion State of Mind, PLLC to speak in written or verbal communication with the source named above about the reasons for my/the client's referral, any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

F. I authorize the source named above to speak in written or verbal communication with Champion State of Mind, PLLC about the reasons for my/the client's referral, any relevant history or diagnoses, and other similar information that can assist with my/the client's receiving treatment or being evaluated or referred elsewhere.

G. The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes require consent of the treating provider or a court order. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.

H. I understand that no service, treatment, eligibility or payment will be denied to me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.

I. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), federal and state law of chapter 228 of Iowa code , which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

J. The potential for information disclosed pursuant to the Authorization to may be subject to re-disclosure by the recipient and no longer be protected by federal law. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom.

K. This request/authorization is valid during the pendency of any claim or demand made by or in behalf of me/the client, and arising out of an accident, injury, or occurrence to me/the client. I understand that I may void this request/ authorization, except for action already taken, at any time by means of a written notification to Champion State of Mind, PLLC revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire one (1) year from the signed date, unless otherwise specified:
_____.

L. I agree that a photocopy and/ or fax of this form is acceptable and is to be considered as valid as the original, but it must be individually signed by me, the releaser, and a witness if necessary.

M. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

N. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

In compliance with 42 C.F.R. Part 2 (Public Law 93-282), federal law, and state law chapter 228 of Iowa code, specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations, is required for the release of HIV-related information, mental health and drug and alcohol information. Unauthorized disclosure may result in criminal and/or civil penalties.

I specifically authorize HIV-related information, mental health and drug and alcohol information contained in these records will be released under this consent indicated here: *(**mark all that apply**)*

- ❑ **Do release HIV-related information**
- ❑ **Do release mental health information**
- ❑ **Do release drug and alcohol information**
- ❑ **Do release genetic information**

Other: _____

_____	_____	_____	
Signature of client	**Printed name**	**Date**	
_____	_____	_____	_____
Signature of parent/guardian/representative	**Printed name**	**Relationship**	**Date**

Signatures:

_____	_____	_____	
Signature of client	**Printed name**	**Date**	
_____	_____	_____	_____
Signature of parent/guardian/representative	**Printed name**	**Relationship**	**Date**

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature (if applicable).

_____	_____	_____
Signature of witness	**Printed name**	**Date**

I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent (if applicable).

_____	_____	_____
Signature of professional	**Printed name**	**Date**

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records