

CLAY COUNTY CENTRAL POINT OF CO-ORDINATION
215 WEST 4TH STREET SUITE 6 SPENCER, IOWA 51301
PHONE: 712-262-9438

RELEASE OF INFORMATION

CONSUMER: _____ SOCIAL SECURITY #: _____

I the undersigned, hereby authorize Clay County staff to release and/or obtain the information indicated below, regarding the above name 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 Individual Service Plan | _____ Referral for new services |
| _____ Coordination of service | _____ Other (specify) _____ |
| _____ Monitoring of services | |
| _____ Financial Eligibility Determination | |

INFORMATION TO BE RELEASE FROM THE CPC OFFICE

- _____ SOCIAL HISTORY INFORMATION
- _____ PROGRESS SUMMARY REPORT
- _____ INDIVIDUAL PROGRAM PLAN
- _____ ANNUAL REVIEW
- _____ DISCHARGE SUMMARY
- _____ OTHER (specify) _____
- _____ _____
- _____ FINANCIAL INFORMATION
- _____ _____

INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:

- _____ SOCIAL HISTORY
- _____ EDUCATIONAL/VOCATIONAL PLANS
- _____ PROGRESS SUMMARY
- _____ PSYCHOLOGICAL VALUATION/REPORTS
- _____ PSYCHIATRIC ASSESSMENT/REPORTS
- _____ MEDICAL HISTORY
- _____ TREATMENT PLAN
- _____ DISCHARGE SUMMARY
- _____ 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 Clay County. 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 the Clay County CPC Administrator at the address shown above.

Signature of Consumer or Legal Guardian: _____

Date: _____

Relationship If Not The Consumer

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to:

Substance Abuse _____ Mental Health _____ HIV-Related Information _____

Consumer Signature

Date

In order for this information to be released, you must sign here and above

Copy given to Consumer on: _____