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
____ Coordination of service
____ Monitoring of services
____ Financial Eligibility Determination
____ Referral for new services
____ Other (specify) ______________________________
____

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: ____________________________________