



**MAIN OFFICE:**  
**LE MARS**  
 P.O. Box 70 • Le Mars, Iowa 51031-0070  
 712-546-4624 • 1-800-325-1192  
 FAX 712-546-9395  
 www.plainsareamentalhealth.org

**AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF MENTAL HEALTH INFORMATION**

TO: \_\_\_\_\_  
 Agency/Individual

EXPIRATION DATE: I understand that this authorization is effective until the earlier of (i) the termination of all services to Patient, or (ii) if the following is completed: \_\_\_\_\_ (date on which this authorization expires).

PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip Code

REGARDING: CLIENT NAME: \_\_\_\_\_ CLIENT DOB: \_\_\_\_\_

PAMHC Service Provider(s): \_\_\_\_\_

The exchange of the following information has been authorized by the above named client:

FAXED information accepted as original.

- |       |       |       |                                    |
|-------|-------|-------|------------------------------------|
|       | Yes   | No    |                                    |
| Check | _____ | _____ | Psychological Assessment           |
|       | _____ | _____ | Pertinent History                  |
|       | _____ | _____ | Discharge or Closing Summary       |
|       | _____ | _____ | Psychiatric Evaluation             |
|       | _____ | _____ | Pertinent Medical Information      |
|       | _____ | _____ | Prognosis or Response to Treatment |

Information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Privacy Rule.

I understand that PAMHC may not refuse treatment to me if I refuse to sign this authorization.

Other: \_\_\_\_\_

The purpose or need for the disclosure of the above information is: \_\_\_\_\_

**Signature of Client or Authorized Representative:** \_\_\_\_\_

I understand that I may revoke this Authorization at any time by giving written notice to Plains Area Mental Health Center.

Date Signed: \_\_\_\_\_

\*\*\*\*\*  
 SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW

**I specifically authorize the release of information relating to:**  
 (Client must **initial** appropriate items)

- Mental Health Information
- Substance Abuse (alcohol/drug abuse - client must initial & sign regardless of age) \_\_\_\_\_
- HIV Information

**Client Signature**

\_\_\_\_\_  
 Signature of Client or Authorized Representative - Date

\_\_\_\_\_  
 Address City State

**Initial** → \_\_\_\_\_ I understand that I may review the disclosed information with professional staff. \_\_\_\_ Yes \_\_\_\_ No

Confidentiality of mental health information is protected by federal and state law, i.e. Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part.2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.  
 1/07kk

**CHEROKEE - STORM LAKE**  
 P.O. Box 972 • Cherokee, IA 51012-0972  
 712-225-2575

**SATELLITE OFFICES:**  
**IDA GROVE:**  
 P.O. Box 168 • Ida Grove, IA 51445-0168  
 712-364-3500

**ORANGE CITY**  
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