Multi-Party Consent for Release of Medical, Mental Health, and Substance Use Disorder Information

Please neatly PRINT and provide complete information in each section.

PATIENT INFORMATION

Name______________________________________ **Date of Birth**____________________

I hereby authorize the following organizations:

1. Primary Health Care, Inc., Centralized Medical Records Dept. 1200 University Ave., Suite 200, Des Moines, IA 50314 | Fax: (515) 248-1832
   - Including the substance use disorder program provided at/by: ____________________________
2. ____
3. ____
4. ____

To communicate with and disclose to one another the following health information:

Check the information to be disclosed:

- ❑ **My name and personal identifying information**
- ❑ **My status as a patient substance use disorder treatment**
- ❑ **Initial and subsequent evaluations of my service needs**
- ❑ **Summaries of substance use disorder and mental health assessment results and history**
- ❑ **Summary of substance use disorder and mental health services plan(s), progress and compliance**
- ❑ **Attendance in substance use disorder and mental health services**
- ❑ **Date of discharge from substance use disorder treatment and mental health services and discharge status**
- ❑ **Other** __________________________________
- ❑ **Medication List**
- ❑ **Allergy List**
- ❑ **Immunization Record**
- ❑ **Problem List**
- ❑ **History and Physical**
- ❑ **Discharge Summary**
- ❑ **Laboratory Results**
- ❑ **X-ray/Imaging**
- ❑ **Consultation Reports**
- ❑ **Billing Information**

The purpose of the disclosures among and between the named organizations is <u>to evaluate my need for treatment and other services and to provide and coordinate my treatment and other services</u> I understand that the named organizations will communicate about and disclose records and other information related to my past, current and future health information, including my medical, mental health and substance use disorder treatment. I understand that all the health information I designated above for disclosure will be shared with all of the named organizations. To limit the disclosure to only certain organizations or certain health information, a separate consent form is available.

This consent expires automatically 12 months from the date of my signature unless I revoke the consent earlier. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer. Requests to revoke this consent must be sent in writing to the appropriate named organization.

I understand that completing this form is voluntary. The named organizations will not condition treatment, payment, enrollment or eligibility for benefits on completion of this form.

Health information protected by HIPAA that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected. This document does not authorize redisclosure of alcohol and drug abuse records or other medical information beyond the limits of this consent. This information has been disclosed from records protected by federal confidentiality rules for alcohol/drug abuse (42 C.F.R. Part 2) or by state law for mental health and HIV-related information (Iowa code chapter 228). The federal and state laws prohibits further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such regulations and law.

A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

______________________________ ______________________________
Signature of Patient or Legal Guardian — Date

______________________________ ______________________________
Complete Mailing Address/Street/PO Box — City, State, Zip Code

______________________________ ______________________________
Relationship, if not the patient — Witness Signature

Info. Sent: ______________ Notice of prohibition on redisclosure sent: ____________ Date: ______________