Patient Name: **DOB:** **Medicaid #:**

260 33rd Ave SW Suite J
Cedar Rapids, IA 52404

PH: (319) 361-6529
FAX: (319) 343-1059

AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

AUTHORIZATION-The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to Grace C Mae Advocate Center, Inc.

NAME/AGENCY_____

ADDRESS_____**PHONE**_____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

☐ Summaries and notes of participation in treatment. ☐ Evaluations and Recommendations
☐ Psychological and psychiatric testing & evaluation results ☐ Treatment Plan, Progress & Discharge reports
☐ Information relating to medical history ☐ Information relating to social history
Other information_____

C. **PURPOSE-**The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. **SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW-** I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.

☐ Substance abuse (drug or alcohol) information
☒ Mental Health information
☐ AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months (or_____months) from the date it is signed, or if applicable, until the date of the final disposition of the conditional release or other court action in connection with which this consent is given {42 CFR 2.35 J(c)}. Also, the undersigned understands he/she may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon, and by giving written notice to Grace C Mae Advocate Center, Inc.

F. I hereby authorize disclosure of protected health information as indicated above and acknowledge that I may receive a copy of this document upon request.

_____ _____ _____
Client/ Parent/Legal Guardian Signature Date Relationship to Client

_____ _____
Witness Signature Date

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance