# South Central Behavioral Health Region
# Appanoose, Davis, Mahaska, and Wapello
## Authorization to Obtain and/or Disclose Information

| **Individual Name:** | **SSN:** | **DOB:** |
|---|---|---|
| | | |

"I hereby authorize the above named agency to obtain and/or disclose oral and/or written information that has been indicated below with the following individual(s) and/or agency(s):"

**THIS INFORMATION WILL BE OBTAINED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSE:**

☒ Coordination of Services ☒Service Planning ☐Determining Eligibility for Services

☐Monitoring of Services ☒Funding Purposes ☒ Other__communication_____

**INFORMATION TO BE OBTAINED AND/OR DISCLOSED:**

☐Funding and/or Eligibility _____
☐Family and/or Social Data
☐Agency participation, annual plans/reviews, social history, reporting progress, discharge summaries, service planning
☐Evaluation/Assessment_____
☐Educational and/or Vocational Assessment
☐Family and/or Social Data
☐Physical/Mental Status_____
☐Agency(s) and/or Individual(s) participation, annual plans & reviews, social history, progress reporting, discharge summaries, service planning (if applicable)
☐Financial Information _____
☒Other __communication_____
☐Other _____

**SPECIFIC AUTHORIZATION TO OBTAIN AND/OR DISCLOSE INFORMATION PROTECTED BY STATE OR FEDERAL LAW:**

"I specifically authorize the above agency to obtain and/or disclose data or information relating to the following:"

(Please check and initial appropriate boxes)

☒Mental Health ____ (initial) ☒Substance Abuse____ (initial) ☒HIV-AIDS ____ (initial)

| **Authorizing Signature** | **Date** | **Relationship to Client (if applicable):** |
|---|---|---|
| | | |

**AFFIRMATION OF AUTHORIZATION:** "I give the above named agency permission to obtain and/or disclose the information that I have selected on this form with the individual(s) and/or agency(s) that have been listed and only for the purpose selected. This authorization is valid up to one year unless specified below. I understand that I may revoke this authorization at any time. The revocation will take effect on the date it is received in writing. I understand that I may also refuse to sign this authorization and that revocation or refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. As a client, I have the right to access my treatment or other records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost (see staff for details). I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described may be re-disclosed and no longer protected by the regulations."

**This authorization is valid up to one year unless otherwise specified or noted: _____**

| **Authorizing Signature** | **Date** | **Relationship to Client (if applicable)** |
|---|---|---|
| | | |

| **Witness signature (if applicable)** | **Date** |
|---|---|
| | |

**Please send requested information or direct questions to:**

**Please indicate below if you would like a copy of this Authorization. If you <u>do not</u> indicate either below, you will not be given a copy unless you indicate otherwise verbally.**

**I hereby request a copy of this Authorization:** ☐
**I hereby decline a copy of this Authorization:** ☐