CONSENT TO RELEASE/EXCHANGE INFORMATION

I, _____, DOB ___/___/___, authorize:
(Person Served Name – Please Print)

Sieda Behavioral Health and Treatment Services **□ To release to □ To obtain from □ To exchange with**
(Name of Organization to Release the Information)

_____
(Name of Organization or Person to Release the Information)

_____
(Address) (City) (State) (Zip)

_____
(Fax) (Phone) (Email)

Information Specified Below via Oral, Written, and/or Electronic Means:

	Circle One	
Duration of program involvement/ attendance, including all substance use disorder info.	y	n
Summary of treatment participation, including all substance use disorder information	y	n
Evaluations and recommendations, including all substance use disorder information	y	n
Medical History, including all substance use disorder information	y	n
Social History, including all substance use disorder information	y	n
Alcohol and other drug history, including all substance use disorder information	y	n
Legal History, including all substance use disorder information	y	n
Urinalysis results, including all substance use disorder information	y	n
Other (specify) _____	y	n

The purpose of the disclosure authorized in this consent is to:_____

_____
(Purpose of disclosure, as specific as possible)

I understand that I have the following rights in respect to this authorization:

- The right to revoke this authorization by written notification at any time, however, that any release made prior to revocation does not constitute a breach of my rights to confidentiality.
- The right to receive a copy of this authorization.
- The right to review the disclosed information, as described in the Privacy Notice.
- That treatment is not a condition of signing this authorization, but that in certain limited circumstances I may be denied specific treatment if I do not sign a consent form.
- That information disclosed pursuant to this authorization is not subject to re-disclosure by the recipient without written consent
- **I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as follows**:_____

_____
(Specification of the date, event or condition upon which this consent expires)

Specific Authorization for Release of Information Protected by State and/or Federal Law

I specifically authorize the release of information related to (check appropriate box(es):

□ Substance Abuse □ Mental Health □ HIV-Related Information

This information has been disclosed to you from records protected by federal confidentiality rules for substance use disorder records (42 CFR Part 2), state law for mental health records (Iowa Code CH.228), and/or state law for HIV records (Iowa Code Ch. 1421), and HIPPA 45 CFR pts 160 & 164. A general authorization for the release of medical or other information is not sufficient for this purpose. Civil and/or criminal penalties may be applicable to the unauthorized disclosure of this information. The federal rules relating to substance use disorder records restrict any use of the information to criminally investigate or prosecute any substance use disorder patient.

_____ _____
Signature of Individual or Legal Guardian and Date Relationship if not the Individual

_____
Signature of Witness and Date