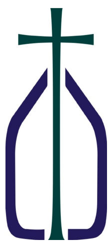


Catholic Charities of the Archdiocese of Dubuque

Administrative Office: 1229 Mount Loretta Avenue P.O. Box 1309, Dubuque, IA 52004-1309
Phone 563-588-0558 or Toll Free 1-800-772-2758

Patient Authorization to Release/Obtain Information

Client's Name: ____DOB: ____________ SSN: ____________________________

THIS INFORMATION MAY BE RELEASED TO OR OBTAINED FROM:

____

I AUTHORIZE CATHOLIC CHARITIES TO VERBALLY OR IN WRITING:

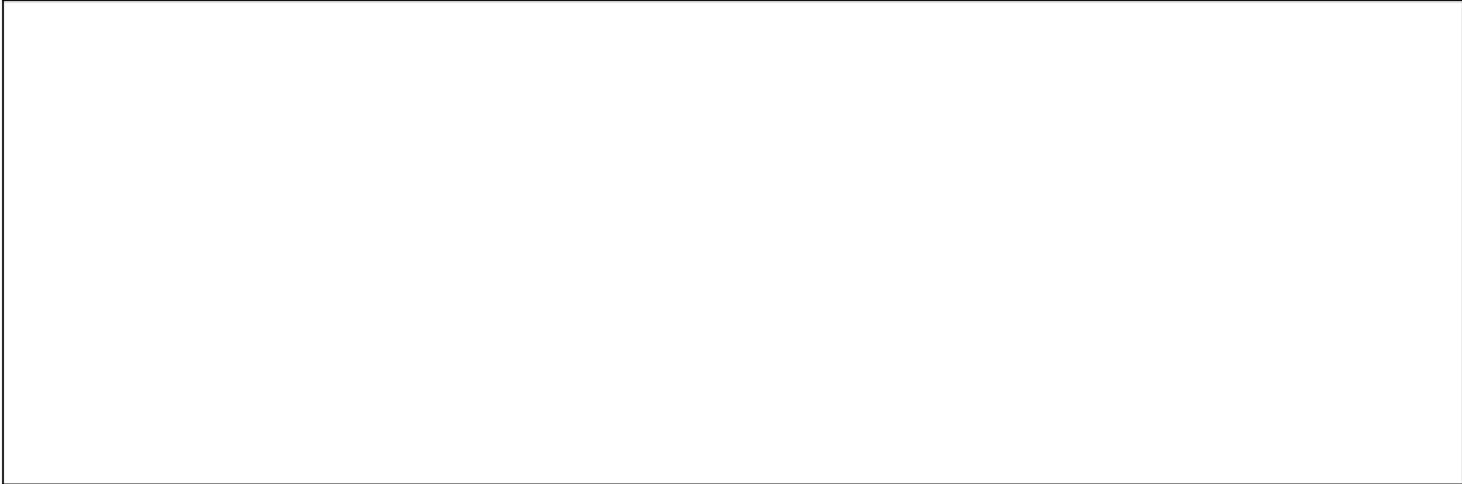
RELEASE THE FOLLOWING INFORMATION:	**OBTAIN THE FOLLOWING INFORMATION:**	
Assessment	History and Physical	Emergency Room Report
Progress Notes	Consultation Reports	Discharge Summary
Discharge Summary	________Assessments	Laboratory Results
Psychiatric/Psychological Evaluation	Psychiatric/Psychological Evaluation	Progress Notes
Other:	Other:	

THIS RELEASE IS REQUESTED FOR THE FOLLOWING PURPOSE:
To communicate and share information so as to provide efficient, effective treatment and make appropriate referrals when necessary in the best interest of the patient.
Other:

RESTRICTIONS REGARDING THIS RELEASE:
Authorization ends one year from the date on the signature, if revoked as noted below, or as specified: ______________________________
Other:

I understand that I have a right to inspect the information which will be released through this authorization and that, if requested, such an inspection will occur in a meeting with the counselor or other authorized staff from Catholic Charities. I understand that I may revoke this authorization by providing a written revocation to the recipient named above and to Catholic Charities. I also understand that any information which has been released prior to the revocation may be used for the purposes listed above. Once this information is disclosed, I understand that this information may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. This is also explained in Catholic Charities Notice of Privacy Practices and that I have been offered a copy of that document.
I understand that I have the right to refuse to give consent for the use of disclosure of protected information for treatment, reimbursement or health care operations and that I have the right to revoke such a consent at any time. However, except for emergency conditions, Catholic Charities reserves the right to refuse treatment, refer you to another provider, or limit treatment options to you if you refuse to give your signed consent for the use of disclosure of protected information for treatment, reimbursement purposes, and/or if the services being requested are due to a court order or for the sole purpose of providing an evaluation report to a third party.

Client Signature/Legal Guardian   Date



SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I authorize the release of data and information relating to:

________ 1. Substance Abuse
________ 2. Mental Health
________ 3. HIV Related Information

_______________________________________ _____________
Client Signature/Legal Guardian Date

_______________________________________ _____________
Client Signature/Legal Guardian Date

I have received a copy of this release of information
_____________ (Initial)

Witnessed by: ____

PROHIBITION OF REDISCLOSURES

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for alcohol/drug abuse records (42 CFR Part 2), for mental health records (Iowa Code CH 228), or HIV/AIDS (Iowa code CH, 141), federal and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health, or HIV/AIDS information.

C5: Rev 06/2013

Documentation of Information Sent

Date the information was sent:
Summary of what information was sent:
Signature of counselor/administrative staff responsible: