Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Consent to Release Information for Coordination of Care

Client's Name: **Client's DOB:** **Title 19#:**

My Primary Care Provider for medical care is _____

Clinic _____

Communication between your behavioral health provider(s) and your primary care provider (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure in order to obtain enrollment, eligibility, payment, or services with Southwest Iowa Families, Inc.

☐ I **do not** wish for you to contact my primary care provider. Staff have explained any known consequences. Please sign below.

OR

I hereby authorize the verbal & written disclosure of protected health information about the individual named above, including any applicable mental/behavioral health and /or substance abuse information, including diagnosis, treatment plan prognosis, and medication(s) between Southwest Iowa Families, Inc. and the provider listed above to facilitate coordination of care.

1. This release will be valid for no more than one year from the date of the release and may be withdrawn by written request at any time, except to the extent that actions have already been taken in reliance on.
2. A copy of this release is considered valid as the original.
3. A release authorized only exchange of information as indicated and does not allow forwarding of any of the information received to a third party.
4. I hereby acknowledge that I was offered a copy of this release and can request another copy at any time by asking Southwest Iowa Families, Inc. staff.
5. I understand that I may request to review information authorized by release and such review would occur in a meeting with a mental health professional.

_____ _____ _____

Client's Signature Printed Name Date

_____ _____ _____

Legal Guardian's signature & relationship Printed Name
Date

Is there anyone else who is able to legally sign for this individual? Yes No

_____ _____ _____

Name Relationship Date

_____ _____

Witness Date

PROHIBITION ON REDISCLOSURE: 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 or by state law for mental health and HIV-related information, federal requirements (42C.F.R. part 2) and state requirements (Iowa code ch.228) further disclosure is prohibited 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 or other information is not sufficient for these purposes. Civil and / or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

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Consent to Release Information for Coordination of Care

Client's Name: **Client's DOB:** **Title 19#:**

Medications are *not* prescribed by Southwest Iowa Families providers. I will tell my prescriber what medication, including prescribed and over-the-counter medications, I am or have been taking. I will ask my prescriber to educate me regarding the medication that has been prescribed and why. I will ask about the possible side effects of this medication and possible drug and/or food interactions that could occur, including when and how quickly to report side effects. It is recommended that women who are or may become pregnant, or are breastfeeding discuss this with their doctor **before** taking **any** medication.

My prescriber of psychiatric medication (medication for anti-depressants, anti-anxiety, ADHD, & other) is _____Clinic _____
Communication between your behavioral health provider(s) and psychiatric medication prescriber is important to make sure all care is complete, comprehensive, and well-coordinated. This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure in order to obtain enrollment, eligibility, payment or services with Southwest Iowa Families, Inc.

☐ **I do not** take any psychiatric medications. Please sign below. OR
☐ I **do not** wish you to contact him/her/them (Staff have explained any known consequences.) Please sign below. OR
☐ This is my primary care provider listed on the other release OR
☐I have a Psychiatric Advance Directive on file with _____OR
☐ I **do not** have a Psychiatric Advance Directive.

I hereby authorize the verbal and written disclosure of protected health information about the individual named above, including any applicable mental/behavioral health and /or substance abuse information, including diagnosis, treatment plan prognosis, and medication(s) between Southwest Iowa Families, Inc. and the provider listed above to facilitate coordination of care.

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Client's Signature	Printed Name	Date
Legal Guardian's signature & relationship	Printed Name	Date

Is there anyone else who is able to legally sign for this individual? Yes No

Name	Relationship	Date
Witness		Date

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