CHILD PROVIDER LIST AND RELEASES

Please complete the following information regarding the service providers to create releases for information.

Child's Name

DOB

Guardian Requesting Info

Relationship to child

Date of Request

Agency Name	Address	Phone# Fax #	Service Dates Start Date	 End Date
		P- F-		
		P- F-		
		P- F-		
		P- F-		
		P- F-		
		P- F-		

Please review the information below and select information to be released by each provider.

RELEASE FORM

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808 5th Avenue	925 SW Porter Avenue	620 8th Street	925 SW Porter Avenue
Des Moines, IA 50309	Des Moines, IA 50315	Des Moines, IA 50309	Des Moines, IA 50315
515-244-2267	515-285-6781	515-697-5700	515-256-3450
515-244-1922 (fax)	515-287-9695 (fax)	515-697-5701 (fax)	515-256-3451 (fax)

Client Name: ______________________________ Client Birthdate: ______________

I, the undersigned, do authorize and request ______________________________
(name of individual/agency)

to release to Orchard Place information from ____________________ until one year from the date the authorization is signed.
(date)

- ☐ General Medical Care
- ☐ Mental Health
- ☐ Other ______________________________
- ☐ Educational/Developmental Information
- ☐ Drug or Alcohol Abuse

I agree that Orchard Place may release the following information to the above named individual/agency:

- ☐ General Medical Care
- ☐ Mental Health
- ☐ Other ______________________________
- ☐ Educational/Developmental Information
- ☐ Drug or Alcohol Abuse

The information being disclosed may be used only for the following purposes:

- ☐ Case Coordination and Treatment Planning/Communication
- ☐ Medication Decisions
- ☐ Other ______________________________

I understand that I have the right to revoke this authorization at any time by giving written notice to both parties. Any revocation will not affect any release of information occurring prior to receipt by both parties of the revocation. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care.

I understand that I have the right to inspect the information disclosed pursuant to this authorization at any time, subject to such reasonable conditions as may be established by Orchard Place.

I acknowledge that I have carefully read this authorization in its entirety as completed, understand its contents and have signed this authorization as my own free act. I further acknowledge that I have been offered a completed copy of this authorization. A photocopy or exact reproduction of this authorization shall have the same effect as the original.

If this authorization is executed by a person other than the client, that person represents and declares that he/she is the legal representative of the client and has the authority to execute this authorization on behalf of him/her.

Prohibition on Redisclosure: This form does not authorize 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 records, Federal requirements (42 C.F.R. Part 2) and State requirements (Iowa Code Ch 228) 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 or other information is NOT sufficient for these purposes. The Federal rules regarding alcohol/drug abuse information restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Consent to Use & Disclose Health Information: I acknowledge that information to be released may include material that is protected by either state and/or federal law applicable to mental health information. My signature authorizes release of all information as specified above.

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(Signature of Client or Personal Representative)

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(Relationship)

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(Witness)

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(Date)

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