

LINK ASSOCIATES - 4301 NE 14<sup>th</sup> Street -Des Moines, Iowa 50313

RELEASE OF INFORMATION - EXAMPLE

NAME: \_\_\_\_\_ SSN #: \_\_\_\_\_ DOB: \_\_\_\_\_ SID#: \_\_\_\_\_

I the undersigned, hereby authorize Link Associates staff to release and/or obtain the information indicated below, regarding the above named consumer, with:

Name of Person or Agency \_\_\_\_\_

Complete Mailing Address \_\_\_\_\_

The information being released will be used for the following purpose:

- Planning and implementation of Comprehensive Consumer Service Plan
- Coordination of services
- Monitoring of services
- Referral for new services
- Other-Media release as permitted below.

**INFORMATION TO BE RELEASED FROM THE PROGRAM:**

- | Yes                      | No                                  |  |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | SOCIAL HISTORY                                     |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | PROGRESS SUMMARY                                   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | COMPREHENSIVE CONSUMER SERVICE PLAN                |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | ASSESSMENT   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | DISCHARGE SUMMARY                                  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | MEDICATION RELATED INFORMATION                     |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | FINANCIAL INFORMATION                              |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | MENTAL HEALTH                                      |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | RE-RELEASE OF 3 <sup>RD</sup> PARTY INFO (specify) |

**INFORMATION TO BE OBTAINED FROM THE AGENCY INDICATED ABOVE:**

- | Yes                      | No                                  |  |
|--------------------------|-------------------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | SOCIAL HISTORY                                     |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | EDUCATIONAL/VOCATIONAL PLANS                       |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | PROGRESS SUMMARY                                   |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | PSYCHOLOGICAL EVALUATIONS/REPORTS                  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | PSYCHIATRIC ASSESSMENT/REPORTS                     |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | MEDICAL HISTORY                                    |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | TREATMENT PLAN                                     |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | DISCHARGE SUMMARY                                  |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | FINANCIAL/EARNINGS                                 |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | RE-RELEASE OF 3 <sup>RD</sup> PARTY INFO (specify) |

**TAKE & USE PHOTOS &/OR VIDEO FOR PUBLIC RELATIONS PURPOSES:** (circle approved areas or check yes for all of the below)

Newsletters, in-house display, community presentations, brochures/printed material, marketing materials, website, press/media coverage.

**Permission to use photos/media for all of the above:** \_\_\_ Yes \_\_\_ No

**Permission to release name with media:** \_\_\_ Yes \_\_\_ No

This authorization shall expire on: \_\_\_\_\_

At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the recipient named and to the Link Associates Case Management program. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the recipient named, or Link Associates Case Management. **SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I specifically authorize the release of data and information relating to Mental Health:**

Signature of Consumer or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Relationship if Not the Consumer

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

I specifically authorize the release of data and information relating to:

- Substance Abuse (must be signed by the consumer, including minors)
- HIV-Related Information

Consumer/Guardian Signature

Date

In order for this information to be released, you must sign here and above

Copy given to Consumer or Guardian on: \_\_\_\_\_