Bluebird Behavioral Health
309 S. 7th St, Suite C, Adel, IA 50003
Phone: (515) 334-7755 Fax: (515) 809-3855

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient name: _____ Date of Birth:_____
Any previous names under which the records may be kept: _____

I, the undersigned, voluntarily authorize and request, Adel Mental Health/Bluebird Behavioral Health to
☐ **Release to:**
☐ **Request/Obtain from**:

Organization/Individual:_____
Address:_____City:_____ State:_____Zip:_____
Phone Number:_____ Fax Number:_____

For the following use, purpose, or need:

- ☐ Collaboration of care and services
- ☐ Transfer of care
- ☐ Communication with family member
- ☐ Other_____

This authorization is effective for:

- ☐ Twelve months from the date on which it is signed
- ☐ Indefinitely until revoked

The following information may be disclosed:

- ☐ Complete records.
- ☐ Office Notes
- ☐ Communication Only
- ☐ Other_____

Specific Authorization for Release of Information protected by State or Federal Law
Please *initial* next to each to authorize the specific release of each of the following:
_____Mental Health _____ HIV/AIDS _____Substance Abuse/Alcohol/Drugs _____Genetic Testing

_____
Signature of Patient/Legal Representative **Date**

_____
If Legal Representative, Relationship to patient

I understand that I have the right to request a copy of this form after I sign it. I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that this authorization is subject to written revocation at any time; however, I understand that revocation of this authorization will not affect any actions taken before the revocation was received or actions taken in reliance thereon. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing. I agree that the information may be faxed or emailed for expediency. Uses and disclosures of protected health information may be permitted without prior consent in the event of an emergency, when a provider is required by law, to healthcare providers who have indirect relationships with the patient, such as laboratories, health plans, and healthcare clearinghouses. Prohibition of Redisclosure - This form does not authorize the redisclosure 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 and HIV/AIDS test results, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.228 & ch.141) prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes.
NOTE: PHOTOCOPY OF THIS SIGNED AUTHORIZATION SHALL BE AS EFFECTIVE AS THE ORIGINAL.