IVRS Use Only:
Date Sent: _____
Sent by: _____
Staff Initials: _____

State of Iowa
Iowa Workforce Development
Iowa Vocational Rehabilitation Services

RE: _____ _____
NAME *(Typed or Printed)* **DATE OF BIRTH** *and/or* **SS#/OTHER IDENTIFIER**

AUTHORITY FOR RELEASE OF INFORMATION and/or RIGHT TO COMMUNICATE

I, the undersigned, hereby authorize and agree to disclosure of information between the two parties listed below:

RELEASE OF INFORMATION:
The following specific information covering the approximate date(s): _____

- ❑ Medical: Diagnosis(es), Evaluations, and Treatment Records
- ❑ Hospital: Admission Records, Consultant Exams, and Discharge Summaries
- ❑ Psychiatric: DSM Diagnosis(es), Evaluations, Treatment Records, Clinical Notes, and Discharge Summaries
- ❑ Psychological: DSM Diagnosis(es), Evaluations, Treatment Records, Clinical Notes, and Discharge Summaries
- ❑ Transcript of Grades, Performance Reports, Test Results, and IEPs
- ❑ Other _____

RIGHT TO COMMUNICATE:

❑ I, the undersigned, consent to communication between the people listed below regarding IVRS services. The information shared between the parties listed above will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of rehabilitation services; however, this consent does not grant decision-making authority. Without a court-ordered guardianship or other valid legal authority in place, no party shall have the right to make decisions for client.

I understand that the information may be given verbally or in written form and this release includes permission to furnish IVRS copies. This form will be kept in my IVRS case record, and I understand that I may review the disclosed information by contacting the person, agency, or entity releasing the information. I understand that the information will be used for purposes relating to my rehabilitation programming and will not be released to any other person, agency, or entity for any purpose without my written permission except as required by Federal or State Law. Disclosure of this information carries with it the potential for unauthorized redisclosure. Once information is disclosed it may no longer be protected by federal privacy regulations. I understand that any action on my part to deny access to information that is essential to my rehabilitation programming may result in delaying or stopping rehabilitation services. I also understand that I may withdraw this permission at any time by sending written notice to Iowa Vocational Rehabilitation Services, 1000 E Grand Ave, Des Moines, Iowa 50319. If I withdraw my permission, I understand that the withdrawal does not apply to information already received by IVRS prior to my written withdrawal. In the absence of any withdrawal or special instructions below, **this release will automatically expire 12 months from the date of my signature.**

Restrictions and/or Comments: _____

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

I understand that information may be released electronically and may include information in the following categories unless I specifically deny the release **(initial any category not to be released)**.

Substance Abuse _____ Mental Health _____ HIV-Related Information _____

In accordance with 45 CFR §164.058, I understand that by signing this authorization my treatment, payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Federal Law including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 42 CFR Part 2 (for alcohol/drug abuse), and/or State Law (Iowa Code Ch.228) for Mental Health, prohibit information disclosed from records protected by these laws from being redisclosed, even to the client, without the specific written consent of the client or as otherwise permitted by such law and/or regulations.

Use of Electronic Signatures: The Uniform Electronic Transactions Act, the ESIGN Act, and Iowa Code 554D provide for the use of electronic signatures. Under that guidance, electronic signatures will be accepted for this release.

_____ _____
CLIENT SIGNATURE DATE PARENT/GUARDIAN SIGNATURE, IF APPLICABLE DATE

_____ _____
CLIENT STREET/P.O. BOX WITNESS SIGNATURE, IF REQUIRED BY STATE LAW DATE

_____
CLIENT CITY/STATE/ZIP