IOWA DEPARTMENT OF CORRECTIONS and
IOWA DEPARTMENT OF CORRECTIONAL SERVICES JUDICIAL DISTRICTS
Consent to Release Information

Patient/Client Last Name, First, MI _____ ICON Number _____ Date of Birth _____

I authorize the
- ☐ IOWA DEPARTMENT OF CORRECTIONS
- ☐ IOWA DEPARTMENT OF CORRECTIONAL SERVICES JUDICIAL DISTRICTS
- ☐ ANCHOR Center

Address: _____

☐ To obtain records and information noted below, in oral, written, electronic or other format from . . .
☐ To release records and information noted below, in oral, written, electronic or other format from . . .

Agency/Organization/Individual _____

Address _____ City _____ State _____ Zip _____

Types of Information (check all that apply)
- ☐ Medical
- ☐ Hospital
- ☐ Psychiatric
- ☐ Psychological
- ☐ Alcohol, Drug and Substance Use or Treatment
- ☐ Discipline and Time Computation
- ☐ Other (specify) _____

For the following purposes (check all that apply)
- ☐ Treatment
- ☐ Supervision
- ☐ Publix and Private Benefits Programs
- ☐ Employment
- ☐ Housing
- ☐ Referral
- ☐ Other (specify) _____

Specific Authorization for Information Protected by State or Federal Law

I specifically authorize the release and disclosure of records and information about my (check and initial all that apply)

1. Substance Abuse (Drug, Alcohol)	☐	_____ Initials
2. Mental Health	☐	_____ Initials
3. HIV/AIDS Related Information	☐	_____ Initials
4. Genetic Testing	☐	_____ Initials
5. Developmental Disabilities	☐	_____ Initials
6. Sexually Transmitted Diseases	☐	_____ Initials

_____ Patient/Client/Legal Guardian Signature _____ Date

I understand that my protected health information, as well as records and information about my alcohol or drug substance abuse treatment, mental health, HIV/AIDS, and genetic testing are protected under federal or state law and regulations. These include the Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and Iowa Code Chapter 228 regarding Mental Health and Psychological Information. These laws prohibit re-disclosure of mental health, alcohol and drug abuse treatment, HIV/AIDS, genetic testing, mental health and other confidential information without my written consent except in certain circumstances. I may revoke this consent at any time. I may request to inspect disclosed health information by providing written notice to the Iowa Department of Corrections or the Iowa Department of Correctional Services offices. Any release of information or records which has been made prior to my revocation, and which has been made in reliance upon this authorization, shall not constitute a breach of my rights to confidentiality. Once the requested information has been disclosed, the recipient of the information may re-disclose it and the privacy regulations guaranteed with this consent to release information may no longer protect the information. The Department of Corrections and Department of Correctional Services may not require this form as a condition of treatment or services. However, when the provision of services is solely for the purpose of creating a medical report using protected health information for a third party, refusal to sign may result in denial of those services. My consent will expire one year from the date it is signed, or on _____, whichever is earlier, and will automatically expire without notice to me at the time my institutional or community based correctional supervision is completed.

_____ Patient/Client/Legal Guardian Signature _____ Date _____ Witness Signature _____ Date