Optimae LifeServices
AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose: ☐ Treatment ☐ Payment ☐ Health Operations

INDIVIDUAL: _____ SOCIAL SECURITY# _____
INDIVIDUAL ADDRESS: _____
TITLE XIX # _____ (If Applicable) BIRTH DATE: _____
I the undersigned, hereby authorize Optimae staff to release and/or obtain verbal, electronic, or written information indicated below, regarding the above named individual with:

Name of Person or Agency: _____

Complete Mailing Address: _____

Description of each purpose(s):

☐ Referral for new services
☐ Establishing eligibility for services
☐ Planning & implementation of Service Plan
☐ Coordination of Services
☐ Other _____

INFORMATION TO BE DISCLOSED FROM OPTIMAE:

☐Yes ☐No ANNUAL REVIEW
☐Yes ☐No DISCHARGE SUMMARY
☐Yes ☐No FINANCIAL INFORMATION
☐Yes ☐No SERVICE/TREATMENT PLAN
☐Yes ☐No MEDICAL-HEALTHCARE INFORMATION
☐Yes ☐No PROGRESS SUMMARY
☐Yes ☐No SOCIAL HISTORY
☐Yes ☐No VOCATIONAL INFORMATION
☐Yes ☐No INCIDENTS _____
☐Yes ☐No OTHER (specify) _____

INFORMATION TO BE OBTAINED FROM AGENCY LISTED ABOVE:

☐Yes ☐No DISCHARGE SUMMARY
☐Yes ☐No FINANCIAL INFORMATION
☐Yes ☐No SERVICE/TREATMENT PLAN
☐Yes ☐No MEDICAL-HEALTHCARE INFORMATION
☐Yes ☐No PROGRESS SUMMARY
☐Yes ☐No SOCIAL HISTORY
☐Yes ☐No VOCATIONAL INFORMATION
☐Yes ☐No EDUCATIONAL PLANS
☐Yes ☐No OTHER (specify) _____

Description of specifics: _____

To Be Disclosed By Mental Health Services:

☐Yes ☐No PSYCHIATRIC ASSESSMENT/REPORT
☐Yes ☐No PSYCHOLOGICAL EVALUATION

To Be Obtained From Originating Source:

☐Yes ☐No PSYCHIATRIC ASSESSMENT/REPORT
☐Yes ☐No PSYCHOLOGICAL EVALUATION

1. I understand that the Provider cannot guarantee that the Recipient will not disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. I also understand that I may review the disclosed information and ask questions by contacting the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Optimae except when I am (i) receiving research-related treatment or (ii) receiving healthcare solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at 226 W. Main Ottumwa, Iowa 52501 or (641)777-9852.

4. I understand that the 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 _____ Genetic tests/info*** _____

** Information has been disclosed to you from records protected by federal confidentiality rules (42 CFR 42 CFR Part 2 prohibits unauthorized disclosure of these records). ***Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.

5. This document is valid for one year unless otherwise specified. This document is valid until _____.

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:

_____ _____
Individual Signature Date

_____ _____ _____
Guardian Printed Name Guardian Signature Date

Date copy given to Individual or Guardian: _____ ☐ Check if customer or guardian declines to receive a copy

Send information to: _____