

**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):**

- |  |   |
|--|---|
| <input type="checkbox"/> Referral for new services                 | <input type="checkbox"/> Coordination of Services |
| <input type="checkbox"/> Establishing eligibility for services     | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Planning & implementation of Service Plan |   |

**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: \_\_\_\_\_