

**WASHINGTON COUNTY CENTRAL POINT OF COORDINATION(CPC)
Authorization to Obtain and/or Disclose Information**

Individual Name:		SSN:	DOB:
"I hereby authorize the CPC staff to obtain and/or disclose oral and/or written information that has been indicated below with the following individual(s) and/or agency(s):"			
Address of agency/individual listed above:		Phone & Fax #'s of agency/individual listed above:	
<u>THIS INFORMATION WILL BE OBTAINED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSE:</u>			
<input type="checkbox"/> Coordination of Services	<input type="checkbox"/> Service Planning	<input type="checkbox"/> Determining Eligibility for Services	
<input type="checkbox"/> Monitoring of Services	<input type="checkbox"/> Funding Purposes	<input type="checkbox"/> Other _____	
<u>INFORMATION TO BE OBTAINED AND/OR DISCLOSED:</u>			
<input type="checkbox"/> Funding and/or Eligibility _____ <input type="checkbox"/> Evaluation/Assessment _____ <input type="checkbox"/> Educational and/or Vocational Assessment _____ <input type="checkbox"/> Family and/or Social Data _____ <input type="checkbox"/> Physical/Mental Status _____ <input type="checkbox"/> Agency(s) and/or Individual(s) participation, annual plans & reviews, social history, progress reporting, discharge summaries, service planning (if applicable) <input type="checkbox"/> Financial Information _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____			
<u>SPECIFIC AUTHORIZATION TO OBTAIN AND/OR DISCLOSE INFORMATION PROTECTED BY STATE OR FEDERAL LAW:</u>			
"I specifically authorize CPC staff to obtain and/or disclose data or information relating to the following:" (Please check and initial appropriate boxes)			
<input checked="" type="checkbox"/> Mental Health <input type="checkbox"/> (initial) <input type="checkbox"/> Substance Abuse <input type="checkbox"/> (initial) <input type="checkbox"/> HIV-AIDS <input type="checkbox"/> (initial)			
Authorizing Signature	Date	Relationship to Client (if applicable):	
AFFIRMATION OF AUTHORIZATION: "I give the above named agency permission to obtain and/or disclose the information that I have selected on this form with the individual(s) and/or agency(s) that have been listed and only for the purpose selected. This authorization is valid up to one year unless specified below. I understand that I may revoke this authorization at any time. The revocation will take effect on the date it is received in writing. I understand that I may also refuse to sign this authorization and that revocation or refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits. As a client, I have the right to access my treatment or other records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost (see staff for details). I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulation or a business associate of these entities, the information described may be re-disclosed and no longer protected by the regulations."			
This authorization is valid up to one year unless otherwise specified or noted: _____			
Authorizing Signature	Date	Relationship to Client (if applicable)	
Witness signature (if applicable)			Date

Please send requested information or direct questions to:

Washington County
 Mental Health Disability Services
 2175 Lexington Blvd., Bldg. 2
 PO Box 902
 Washington, IA 52353

Please indicate below if you would like a copy of this Authorization. If you **do not** indicate either, you will not be given a copy unless you request one verbally.

I request a copy of this Authorization:
 I decline a copy of this Authorization: