HILLCREST FAMILY SERVICES

AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF CONFIDENTIAL INFORMATION

Client(s): ______________________________

Medicaid # : ______________ SS #: ______________ DOB: ______________

I/We hereby authorize STAFF of Hillcrest Family Services' MENTAL HEALTH CENTER

Program, (program address:) 200 MERCY DRIVE SUITE 200 DUBUQUE, IOWA 52001 to release and/or obtain the information indicated below regarding the above-named client with:

Name of Person/Agency: RECORDS DEPOSITION SERVICE, INC.

Complete Address: 120 W. MADISON STREET, STE. 300, CHICAGO, IL 60602 P: 312-553-8900 F: 312-553-8901

The information being released will be used for the following purpose(s):

_____ Planning and implementation of my individual Program

_____ Coordination/monitoring of services

_____ Referral of new services

X Other (specify: FOR DISCOVERY BEFORE TRIAL

INFORMATION TO BE RELEASED/OBTAINED *(Please be as specific as possible including from/to dates. For example: Lab results, Social History, Progress Reports, Treatment Plan, Medical History, Educational/Vocational Records, Psychological Testing/Evaluations, Psychiatric Evaluations, etc.):* ALL RECORDS, VERBAL & WRITTEN COMMUNICATION (UNLESS OTHERWISE SPECIFIED)

This authorization is effective for 12-months (or ______________) after the date it is signed. This release will automatically be revoked 30-days after discharge.

This information has been disclosed to you from records protected by Federal and Iowa State Confidentiality rules CFR 42, Part 2, Iowa Chapter 228 of the Iowa Code. These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical and other information is NOT sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that I may review the disclosed information by contacting the Director of Clinical Services, Hillcrest Family Services, 2005 Asbury Road, Dubuque, IA 52001. Hillcrest Family Services will not make the signing of the Release of Information a condition of your treatment, enrollment, or eligibility for services.

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

I specifically authorize the release of data and information relating to:

X Substance Abuse X Mental Health _____ HIV Related Information

Client Signature: ______________________________ Date: ______________

Parent/Guardian/Legal Representative: ______________________________ Date: ______________

In order for this information to be released, you must sign here and below.

AUTHORITY TO RE-DISCLOSE

I understand that the information that is furnished to Hillcrest Family Services may be divulged in a court proceeding or in an administrative agency proceeding. Without further authorization, I authorize Hillcrest Family Services to re-disclose the information they receive to administrative agency or court judicial officers hearing a case which involves me that I understand such disclosure may be furnishing the appropriate agency or court officials with the documents Hillcrest has obtained or by providing a summarization or synthesis of the documents.

I understand that I may revoke this authorization by providing a written statement to the recipient named above and to Hillcrest Family Services. I also understand that any information released prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

______________________________ Client Signature Date

______________________________ Parent/Guardian/Legal Representative Date

______________________________ Client Signature Date

______________________________ Witness Date