



## Consent and Authorization for Release of Information

The Project of the Quad Cities  
4101 John Deere Road, Moline, IL 61265 Phone:  
309-762-5433 Fax: 309-762-4481

### CLIENT INFORMATION

Name on Legal Documents (Last, First, Middle Initial):

Name You Go By:

Date of Birth:

Phone Number:

Address:

I authorize The Project of the Quad Cities to:  OBTAIN from  DISCLOSE information to

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADAP                           | <input type="checkbox"/> Genesis Health Systems     | <input type="checkbox"/> Henry County Health Dept       |
| <input type="checkbox"/> Iowa DHS                       | <input type="checkbox"/> University of Iowa Clinics | <input type="checkbox"/> Mercer County Health Dept      |
| <input type="checkbox"/> Illinois DHS                   | <input type="checkbox"/> UnityPoint Health          | <input type="checkbox"/> Bureau County Health Dept      |
| <input type="checkbox"/> DeLaCerde House                | <input type="checkbox"/> ReCept Pharmacy            | <input type="checkbox"/> Rock Island County Health Dept |
| <input type="checkbox"/> Social Security Administration | <input type="checkbox"/> Two Rivers Pharmacy        | <input type="checkbox"/> Winnebago County Health Dept   |
| <input type="checkbox"/> Other: _____                   | <input type="checkbox"/> Other: _____               | <input type="checkbox"/> DeKalb County Health Dept      |
| <input type="checkbox"/> Other: _____                   | <input type="checkbox"/> Other: _____               | <input type="checkbox"/> Scott County Health Dept       |

Information to be disclosed from DATE (or RANGE OF DATES): \_\_\_\_\_

### INFORMATION TO BE DISCLOSED

Please check what information you want released:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> All Medical Records           | <input type="checkbox"/> All Mental Health Records | <input type="checkbox"/> Confirmation of Contact              |
| <input type="checkbox"/> History and Physical          | <input type="checkbox"/> Mental Health Assessment  | <input type="checkbox"/> Frequency and Duration of Contact    |
| <input type="checkbox"/> Laboratory Results            | <input type="checkbox"/> Treatment Plan            | <input type="checkbox"/> Billing Information                  |
| <input type="checkbox"/> Urinalysis Results            | <input type="checkbox"/> Progress/Contact Notes    | <input type="checkbox"/> Other Records: _____                 |
| <input type="checkbox"/> Physician's Discharge Summary | <input type="checkbox"/> Safety Plan               | <input type="checkbox"/> Redisclosure Information from: _____ |
| <input type="checkbox"/> HIV/AIDS Information          | <input type="checkbox"/> Discharge Summary         |   |

### PURPOSE FOR DISCLOSURE/COMMUNICATION

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Social Security Disability | <input type="checkbox"/> Inform contact person in event of emergency |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Legal Reasons              | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Insurance          | <input type="checkbox"/> Personal Use               |  |

### EXPIRATION OF AUTHORIZATION

This authorization is valid until calendar date: (No more than 1 year from date signed): \_\_\_\_\_  
Unless an earlier date is specified, this authorization will expire 12 months from date of signature below.

### SIGNATURE

- (a) I, or my authorized representative, request that health information regarding my care and treatment be released as set fourth on this form and understand the terms.
- (b) I acknowledge that data to be released may include material that is protected by federal law and that is acceptable to either Mental Health Information, Drug/Alcohol Use/Abuse, and HIV/AIDS.
- (c) I understand that if the recipient of this information is not a health plan or provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations. By signing this consent, I absolve the releasing party from liability related to release of information contained on this form.
- (d) Federal Regulations (42CRF. Part 2) prohibits making further disclosure of this information without specific written consent of the person to whom it pertains or if that person is a minor, their parent or guardian.
- (e) I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. This revocation of consent for release must be in writing, dated, and witnessed.
- (f) I have the right to obtain, upon request, a list of entities to whom my information has been disclosed pursuant to the general designation.

Client Legal Signature (Minor's signature if 12-17)

Date

Parent/Guardian/Authorized Representative Signature

Relationship to Client

Date

Witness Signature (Invalid document if signature is not witnessed)

Date