



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Dear _____ :

The Department of Human Services is pleased to offer a supportive option called Community Care to families. The Community Care program is provided by the Mid-Iowa Family Therapy Clinic, Inc. It offers child and family focused services designed to empower families, prevent the need for future DHS involvement, and help families build ongoing connections to community resources.

Community Care is a voluntary program. Your family is not required to accept a referral to Community Care. If you agree to be referred and later decide you no longer want to participate, you may stop services at any time.

If you wish to be referred to Mid-Iowa Family Therapy Clinic, Inc. for Community Care services, you need to read and sign the attached *Authorization to Obtain or Release Health Care Information*, form 470-3951. The Department will then provide Mid-Iowa Family Therapy Clinic, Inc. with your name, family contact information, and a copy of the current child abuse assessment report completed on your family, which includes family risk and safety assessment information. This agency will not release this information to anyone else without your permission. Staff from the Community Care agency will contact you within 14 days to explain their services.

The Community Care provider will only let the Department of Human Services know whether you accepted or declined services, the general categories of services you received, when services to your family were closed, and the reason services ended.

Community Care is a great option for families looking for support to make themselves stronger. I hope you will consider this program as a way to help your family. Please contact me at _____ if you have any questions.

Sincerely,

DHS Child Protection Worker

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Client Name:	ID#:	SS#:
Date of Birth:	Parent/Guardian:	

I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive . . .

Name or agency to release and receive information: Iowa Department of Human Services - County Office	
Address:	
City/State/Zip:	
Phone:	Fax:

With the following individual or agency:

Name or agency to receive and release information: Mid Iowa Family Therapy Clinic, Inc.	
Address: Box 416, 600 1st Street	
City/State/Zip: Perry, Iowa 50220	
Phone: 515-465-5739	Fax: 515-465-5744

- The information released or shared may include:**
- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Family data photos | <input type="checkbox"/> Social history | <input type="checkbox"/> Lab results | <input type="checkbox"/> Treatment and aftercare plans |
| <input type="checkbox"/> Diagnosis/allergies | <input type="checkbox"/> X-ray/imaging reports | <input type="checkbox"/> Team notes | <input type="checkbox"/> Medication history | <input type="checkbox"/> History & physical exam |
| <input type="checkbox"/> Initial assessment | <input type="checkbox"/> Immunization record | <input type="checkbox"/> School records | <input type="checkbox"/> Court documents | <input type="checkbox"/> Evaluation & recommendations |
| <input type="checkbox"/> Receiving phone calls | | | | |
| <input type="checkbox"/> Consultation reports from (doctor/specialty name): | | | | |
- Other (please specify): 1. DHS will provide the current DHS Child Protective Services Assessment Summary, including risk and safety assessment information; 2. Mid Iowa will provide DHS with information on whether services were accepted, general categories of services provided, and when and why services ended.

Other (note exceptions or limits to this release):

This information is being used ONLY for (state purpose): for the Department to refer you to the Mid Iowa Family Therapy Clinic, Inc. to offer you an opportunity to participate in the Community Care program.

SPECIFIC AUTHORIZATION FOR RELEASE	Type of Information	Authorizing Initials
I authorize the release of the information listed at the right, which requires specific consent under federal law:	Mental health evaluation/treatment*	
	AIDS/HIV-related	
	Substance abuse**	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time by completing form 470-3949, Request to Revoke an Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six months after the date it is signed. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that if the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal or state laws that require the information to remain confidential. If I have questions about disclosure of my health information, I can contact (name) DeAnna Thomas at (phone) (515) 281-3044. I have read this form, or it has been read and explained to me, and I understand its content.

Authorizing signature:	Date:	Expiration date:
Relationship to client: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Legal representative <input type="checkbox"/> Nearest living relative <input type="checkbox"/> Other (specify below)		
<input checked="" type="checkbox"/> Not Required	Witness signature:	
<input type="checkbox"/> Required	Witness signature:	

A photocopy of this signed authorization shall have the same force and effect as this original.

RECORD OF DISCLOSURES
(Required for mental health information)

Date	Name of Recipient	Contents Disclosed	Sent By
1.			
2.			
3.			
4.			
5.			

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.

** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

Notice to Recipients of Mental Health Information

In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of Substance Abuse Information

This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of HIV-Related Testing Information

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

For assistance or consultation you may contact the IDHS Diversity Program Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act. If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.