Iowa Veterans Home
Marshalltown, Iowa 50158
(641) 752-1501

CONSENT TO RELEASE OF INFORMATION

NAME ________________________________ Date of Birth _____________________

SSN __________________Claim # ________________Service # _________________

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

(Name and address of organization or individual from whom information is to be released.)

TO DISCLOSE AND/OR DELIVER TO:

(Name and address of person, Institution or organization.)

Iowa Veterans Home
1301 Summit St
Marshalltown, IA 50158

(641)753-4325
(641)844-6303 (fax)

Only the following specific information from the subject records: (specify dates of service rendered). **(See reverse side for specific consents for mental health, substance abuse and or HIV/AIDS information.)**

Progress notes; consultation reports; operative report(s); history and physical exam(s); social history(s); multidisciplinary summaries; Rehabilitation Medicine note(s)/evaluation(s); PT, OT, Corrective Therapy; Laboratory & Radiology Reports; Respiratory Therapy Report(s); Speech & Audiology Report(s); nutrition note(s); discharge summaries; immunization records; appointments

I understand that this information is to be used (Reason for release of information)__________________
____________**Admission processing**____

I also understand that I may revoke this consent at any time by sending a written notice to the discloser of this information. I understand that any release which has been made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand I may review the disclosed information. This authorization will automatically expire one year from the date of signature, except as specified: ____
At that time no express revocation shall be needed to terminate my consent.

DATE ___________________ SIGNATURE _________________________________

RELATIONSHIP _________________________________

475-0859 (Rev 9/08) **(SEE REVERSE SIDE)**

Specific Authorization For Release of:

Mental Health Information ☐ YES ☐ NO ________________
(including neuropsychiatric testing). Date and Initial

Substance Abuse Information ☐ YES ☐ NO ________________
(including drug and alcohol abuse) Date and Initial

HIV/AIDS/ARC Information ☐ YES ☐ NO ________________
Date and Initial

I acknowledge that data to be released **MAY INCLUDE** information that is protected by Federal Law and that it is applicable to any one or all of the above. My signature authorizes release of all specified information.

SIGNATURE DATE

IN ORDER FOR THE ABOVE INFORMATION TO BE RELEASED, YOU MUST SIGN HERE AND ON THE FRONT SIDE.