# ATTACHMENT A

## Income • Resource • Eligibility Verification

## Sioux Rivers Regional Mental Health & Disabilities Services

### 1. PROOF OF LEGAL RESIDENCE REQUIREMENT

Iowa Code 331.294(1): *"County of residence" means the county in this state in which, at the time a person applies for or receives services, the person is living and has established an ongoing presence with the declared, good faith intention of living in the county for a permanent or indefinite period of time. The county of residence of a person who is a homeless person is the county where the homeless person usually sleeps. A person maintains residency in the county in which the person last resided while the person is present in another county receiving services in a hospital, a correctional facility, a halfway house for community-based corrections or substance-related treatment, a nursing facility, an intermediate care facility for persons with an intellectual disability, or a residential care facility, or for the purpose of attending a college or university.*

- A copy of the applicant's driver's license or picture I.D. that shows current address, **OR**
- A copy of a recent bill or piece of mail with a legible postmark delivered by the U.S. Post Office to the client at their current address, **OR**
- If applicant is living in a homeless shelter or community living facility, a letter signed and dated by personnel stating the applicant is residing in that facility.

### 2. HOUSEHOLD INCOME VERIFICATION REQUIREMENTS

**For applicants 18 years of age and over:** Include income of applicant, applicant's spouse or domestic partner, and any children, stepchildren, or wards over the age of 14 that reside with applicant.

**For applicants under the age of 18**: Include income of applicant (if over 14), applicant's parents (or parent and domestic partner), stepparents, or guardians who reside with applicant.

- Copies of payroll stubs for past 60 days from all employers. If a payroll stub reflects year-to-date earnings, only the most recent payroll stubs will be required.
- If applicant or spouse/domestic partner is self employed, provide a copy of most recent Federal tax return completed.
- If applicable, a copy of Supplemental Security (SSI) or Social Security Disability (SSD) determination, pension payment, and child support amount, etc.
- If an applicant indicates that no one in the household has any income, written documentation is required from all applicable adult household members stating as such and evidence of outside assistance such as food stamps, financial help from relatives, etc., must be provided.

### 3. RESOURCE VERIFICATION REQUIREMENTS (Applicant and other applicable household members)

- A copy of all checking account statements for past 2 months
- A copy of all savings account statements for past 2 months
- A copy of a statement from all retirement accounts such as IRAs, 401(k), pension plans, annuities, certificates of deposit, stocks, bonds or trust fund accounts dated no earlier than the previous tax year.

***NOTE: If applicant or applicable household member has a legal payee, all income and resource verification documents must be obtained from the payee and attached to completed MHDS application.***

# Sioux Rivers Regional MHDS Application Form

*For individuals living in: Plymouth, Sioux and Woodbury Counties*

Application Date: _____ Date Received by Office: _____

First Name: _____ Last Name: _____ MI: _____

Nickname: _____ Maiden Name: _____ Birth Date: _____

Ethnic Background: ☐White ☐African American ☐Native American ☐Asian ☐Hispanic ☐Other _____

Sex: ☐Male ☐Female US Citizen: ☐Yes ☐No If you are not a citizen, are you in the country legally? ☐Yes ☐No

SSN#_____ Marital Status: ☐Never married ☐Married ☐Divorced ☐Separated ☐Widowed

Legal Status: ☐Voluntary ☐Involuntary-Civil ☐Involuntary-Criminal ☐Probation ☐Parole ☐Jail/Prison

Are you considered legally blind? ☐Yes ☐No If yes, when was this determined? _____

Primary Phone #: _____ May we leave a message? ☐Yes ☐No

Current Address: _____
Street City State Zip County

I live: ☐ Alone ☐ With Relatives ☐With Unrelated persons

☐Use as current Mailing Address: ☐Yes ☐No If not, _____

Previous Address_____
Street City State Zip County
Begin Date_____ End Date_____

Current Service Providers:

| | Name | Location |
|---|---|---|
| 1. | | |
| 2. | | |

Current Residential Arrangement: (Check applicable arrangement)

☐Private Residence ☐Foster Care/Family Life Home ☐Correctional Facility ☐Homeless/Shelter/Street
☐Other_____

Veteran Status: ☐Yes ☐No Branch & Type of Discharge: _____ Dates of Service: _____

Current Employment: (Check applicable employment)

| | | |
|---|---|---|
| ☐Unemployed, available for work | ☐Unemployed, unavailable for work | ☐Employed, Full time |
| ☐Employed, Part time | ☐Retired | ☐Student |
| ☐Work Activity | ☐Sheltered Work Employment | ☐Supported Employment |
| ☐Vocational Rehabilitation | ☐Seasonally Employed | ☐Armed Forces |
| ☐Homemaker | ☐ Volunteer | ☐Other _____ |

Current Employer: _____ Position: _____
Dates of employment: _____ Hourly Wage: _____ Hours worked weekly: _____

Employment History: (list starting with most recent to previous.)

| Employer | City, State | Job Title | Duties | To/From |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

Education: What is the highest level of education you achieved? _____ # of years _____ Degree

Emergency Contact Person:

Name: _____ Relationship: _____

Address:_____ Phone: _____

Guardian/Conservator appointed by the Court? ☐Yes ☐No
☐Legal Guardian ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.)

Name: _____

Address: _____

Phone: _____

Protective Payee Appointed by Social Security? ☐Yes ☐No
☐Legal Guardian ☐Conservator ☐Protective Payee
(Please check those that apply & write in name, address etc.)

Name: _____

Address: _____

Phone: _____

**List All People In Household:**

| Name | Age | Relationship | Social Security Number |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**INCOME: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc.** *SEE ATTACHMENT A

**If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)**

_____

_____

| Gross Monthly Income (before taxes): (Check Type & fill in amount) | Applicant Amount: | Others in Household Amount: |
|---|---|---|
| ☐ Social Security | | |
| ☐ SSDI | | |
| ☐ SSI | | |
| ☐ Veteran's Benefits | | |
| ☐ Employment Wages | | |
| ☐ FIP | | |
| ☐ Child Support | | |
| ☐ Rental Income | | |
| ☐ Dividends, Interest, Etc | | |
| ☐ Pension | | |
| ☐ Other | | |
| **Total Monthly Income:** | | |

## Household Resources: (Check and fill in amount and location):

| Type | Amount | Bank, Trustee, or Company |
|---|---|---|
| ☐Cash | | |
| ☐Checking Account | | |
| ☐Savings Account | | |
| ☐Certificates of Deposit | | |
| ☐Trust Funds | | |
| ☐Stocks and Bonds (cash value?) | | |
| ☐Burial Fund/Life Ins (cash value?) | | |
| ☐Retirement Funds (cash value?) | | |
| ☐Other _____ | | |
| **Total Resources:** | | |

**Motor Vehicles**: ☐Yes ☐No (include car, truck, motorcycle, boat, recreational vehicle, etc.)

Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____
Make & Year: _____ Estimated value: _____

**Do you, your spouse or dependent children own or have interest in the following:**

House including the one you live in? ☐Yes ☐No Any other real estate or land? ☐Yes ☐No Other?_____ ☐Yes ☐No

If yes to any of the above, please explain: _____

**Have you sold or given away any property in the last five (5) years?** ☐Yes ☐No **If yes, what did you sell or give away?**

_____

**Health Insurance Information: (Check all that apply)**

**Primary Carrier (pays 1st)**

☐Applicant Pays ☐Medicaid ☐Family Planning only
☐Medicare A, B, D ☐Medically Needy ☐ MEPD
☐No Insurance ☐ Private Insurance ☐ HAWK-I

Company Name _____

Address _____

Policy Number: _____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

**Secondary Carrier (pays 2nd)**

☐Applicant Pays ☐Medicaid ☐ Family Planning only
☐Medicare A, B, D ☐ Medically Needy ☐ MEPD
☐No Insurance ☐Private Insurance ☐ HAWK-I

Company Name _____

Address _____

Policy Number_____
(or Medicaid/Title 19 or Medicare Claim Number)
Start Date: _____ Any limits? ☐ Yes ☐ No

Spend down: _____ Deductible: _____

**Referral Source:**

☐Self ☐Community Corrections ☐Family/Friend ☐Social Service Agency
☐Targeted Case Management ☐Other _____ ☐Other Case Management

## Have you applied for any of the public programs listed below?

**(Please check those you have applied for and the status of your referral) Has your application been Approved or Denied? If denied and you appealed, what is the date of appeal _____ ? Have you applied for reconsideration_____. Have you had a hearing with an Administrative Law Judge and what was the date of the scheduled hearing: _____**

☐Social Security_____ ☐SSDI_____ ☐Medicare_____
☐SSI _____ ☐Medicaid_____ ☐Food Assistance: _____
☐Veterans _____ ☐Unemployment_____ ☐FIP _____
☐Other_____ ☐Other_____

**Disability Group/Primary Diagnosis: (If known)**

☐Mental Illness ☐Chronic Mental Illness ☐Intellectual Disability ☐Developmental Disability ☐Substance Abuse ☐Brain Injury

**Specific Diagnosis determined by:_____ Date:_____**
**Axis I: _____Dx Code: _____**
**Axis II:_____ Dx Code: _____**

**Why are you here today? What services do you NEED? (this section must be completed as part of this application!)**

_____
_____
_____

**I certify that the above information is true and complete to the best of my knowledge, and I authorize Sioux Rivers Regional MHDS staff to check for verification of the information provided including verification with Iowa county government and the state of Iowa Dept. of Human Services (DHS) and Iowa Department of Corrections or Community Corrections staff. I understand that the information gathered in this document is for the use of the Sioux Rivers Region to establish my ability to pay for the services requested, and to assure the appropriateness of services requested. I understand that information in this document will remain confidential.**

_____
**Applicant's Signature (or Legal Guardian) Date**

_____
**Signature of other completing form if not Applicant or Legal Guardian Date**

## CONSENT TO OBTAIN AND RELEASE INFORMATION

| Last Name | First | Middle | Other | SS# |
|---|---|---|---|---|
| Street Address | | | | Parent/Guardian |
| City, State, Zip | | | | Address |
| Date of Birth | | | | City, State, Zip |

I authorize reciprocal release of written and oral information about my needs and the services I receive(d) between representatives of ☒**Sioux Rivers,** ☐ Case Management, ☐ DHS, ☐ **Community Services** and the following: (To approve release of information **only to** ☐ County, ☐ Case Management, ☐ DHS, **check** ☐ **Nonreciprocal**).

**Name or Agency to release and/or receive oral and written information (two-way or 'reciprocal' release):**

*Siouxland Mental Health Center*

***The Information to be released, obtained and/or shared may include :***

**( ) Psychiatric Evaluation/Assessment / Admit Report**
**( ) Agency participation, plans, and progress reporting**
**( ) Physical Status (including medical, dental)**
**( ) Face Sheet**
**( ) Individual Comprehensive Plan**
**( ) Psychiatric and medical history**
**( ) Psychological Evaluation/Report**
**( ) Other (please specify)** _____
**( ) Social History**
**( ) Financial Information**
**( ) Discharge Summary**

**Note exceptions or limits to this release:** **Minimum necessary**

***Information being released will be used for the following purpose:***

**( ) Coordination of services** **( ) Monitoring of services** **( ) Referral for new services**
**( ) Planning & implementation of my Individual Comprehensive Plan**
**( ) Other (note exception)** _____

## SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, OR AIDS-RELATED INFORMATION

**I specifically authorize the release of confidential information relating to:**

| *Type of information* | *Authorizing Initials* |
|---|---|
| Mental health evaluation/treatment | |
| HIV-related | |
| Substance abuse | |
| Other (name): | |

I understand this information shall be kept confidential and shall be used for the delivery of my services. I understand that I have the right to see this information at any time. This consent is valid for information already in existence and any information which may be generated during future service involvement. I understand that I can revoke my consent at any time by providing written notification to the service planner. This consent shall expire upon termination of services, or on the date specified below by the authorizing party. This consent is not automatically renewable.

***I have read this form, or it has been read and explained to me, and I understand its content.***

| Authorizing Signature |
|---|
| Date |
| Relationship to consumer **(if other than self)** |
| Expiration date (if other than one year beyond signature date |

Send information for : ☒ **Sioux Rivers** or
☐ _____Co. Case Management or ☐ DHS to:

**JULIE ALBRIGHT**
**SIOUX RIVERS FUNDING COORDINATOR**
**1211 TRI VIEW AVENUE, SUITE B**
**SIOUX CITY, IA 51103**

**PHONE: (712) 279-6459**

*Copy given to consumer on*: _____

## 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 ON NONDISCRIMINATION

No person shall be discriminated against because of race, creed, color, sex, age, physical or mental disability, religion, national origin or political belief regarding employment or when applying for or receiving benefits or services from the Iowa Department of Human Services, the county, or any of their vendors, purchased service providers, or contractors.

If you have reason to believe that you have been discriminated against for any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services (IDHS) by completing a Discrimination Complaint form. Any IDHS office, institution, or the IDHS Diversity Programs Unit can provide you with this form. If you have reason to believe that you have been discriminated against by a county for any of the reasons stated above, you may contact that county. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were discriminated against **because of** your race, creed, color, national origin, sex, religion, or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

For assistance or consultation you may contact the IDHS Diversity Programs Unit. Complaints should be filed promptly, but in most instances, no later than 180 days of the alleged discriminatory act.

Iowa Department of Human Services
Diversity Programs Unit 1st Fl
1305 E Walnut St
Des Moines IA 50319-0114

Iowa Civil Rights Commission
400 E 14th St
Des Moines IA 50319-1004

County Central Point of Coordination Administrator

US Dept. of Health and Human Services
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106-2808
(FIP, Medical and Services only)

470-3951 (Rev. 8/03) White: Source of Information Yellow: Client Pink: Control

**Authorization for the Use or Disclosure of Confidential Information**

Counties and Mental Health and Disability Services Regions in the State of Iowa (referred to hereafter as "Entity")

NOTE: A PHOTOCOPY OF THIS SIGNED AUTHORIZATION IS HEREBY AS EFFECTIVE AS THE ORIGINAL.

**As required by the Health Insurance Portability and Accountability Act of 1996, the Entity may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. Additionally, Iowa Code §§ 228, 125, 141A and 252.25 require authorization for the release of certain confidential information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information and other confidential information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning the signed revocation section to this office.**

**AUTHORIZATION SECTION**

Client Name: _____ Date of Birth: _____ Client #: _____

Address: _____

I, the undersigned, hereby authorize the Entity staff to release the information indicated below, regarding the above named client, with any Iowa counties or Iowa Mental Health and Disability Services Regions ("Regions") listed on Exhibit A, attached hereto, and/or with providers or agencies who have arranged with the counties or Regions to perform related duties on behalf of the counties or Regions, and with Polk County Health Services (a list of the current affiliated case management entities and other providers is available upon request), **with the exception of the following Iowa counties, Regions or other entities:** _____.

The undersigned authorizes the Iowa counties and Regions listed on Exhibit A, and/or the case management and other providers who are affiliated with the Iowa counties or Regions listed on Exhibit A, to share the following information with each other for the purposes identified below.

| **Information to be disclosed includes:** | **For the following purposes:** |
|---|---|
| Billing information, including claims payment and claims history; Funding authorizations; Other services received including hospitalizations; Medical record including diagnosis information; Employment information; Education information; Resources and income; Medical History; Medications; Allergies; Case Management Information including: service plans, social history, discharge summaries and client contact information; and All applications, investigation reports, and case records related to county general assistance described in Iowa Code § 252.25. | Parties will access/disclose records for the purposes of: coordinating treatment, paying claims, determining benefit eligibility, obtaining authorizations and abiding by state and federal reporting requirements. |

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

I hereby specifically authorize the release and sharing of information relating to: (Check & Sign any that apply)

| ☐ HIV/AIDS Related Testing Information | ☐ Mental Health Information (**NOTE**: This Authorization may not be used to authorize the use or disclosure of psychotherapy notes. The client has the right to inspect any disclosed Mental Health Information at any time. If Mental Health Information is disclosed, a copy of this Authorization shall be included in the client's record of Mental Health Information). | ☐ Chemical Dependency (Drug/Alcohol) Treatment Information. (**NOTE**: Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed.) |
|---|---|---|
| X_____ Client initials required | X_____ Client initials required | X_____ Client initials required |

**Expiration Date. This Authorization is in effect from the date of your signature until it is revoked, unless a different date is listed below:**
☐ ____/____/____ (specify date).

This authorization may be revoked at any time by signing the revocation section on your copy of this form and returning it to the Entity at the address listed at the top of this form, except to the extent that action has been taken in reliance on this Authorization. You are not required to sign this Authorization as a condition of obtaining treatment, payment, enrollment or eligibility for benefits. You may inspect and/or copy the information disclosed. Some information disclosed pursuant to this Authorization potentially could be subject to redisclosure by the recipient, and if redisclosed, the information would no longer be protected by the federal privacy rule.

**By signing below, I acknowledge that I have read and I understand this Authorization form. I also acknowledge receipt of a copy of this Authorization form.**

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the client, please indicate relationship:

☐ parent or guardian of minor client
☐ guardian or conservator of a client (if and to the extent authorized under State law)
☐ personal representative of deceased client
☐ other (specify) _____

Copy sent to Client/Guardian on: _____ (date) at following address: _____

**A COPY OF THIS SIGNED AUTHORIZATION MUST BE GIVEN TO THE CLIENT OR CLIENT'S PERSONAL REPRESENTATIVE**

**Notice to Recipients of Mental Health Information:** In accordance with 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. The unauthorized disclosure of mental health information is unlawful. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

**Notice to Recipients of Substance Abuse Treatment Information:** This information may have been disclosed to you from records whose confidentiality is protected by Iowa Code Chapter 125. Information protected by the Federal confidentiality law (42 CFR Part 2) will not be disclosed.

**Notice to Recipients of HIV-Related Testing Information:** This information may have been disclosed to you from records whose confidentiality is protected by state law, and penalties under Iowa Code Chapter 141A apply to the unauthorized disclosure of these records.

**EXHIBIT A**

| Iowa Counties: | | | Iowa Mental Health and Disability Services Regions: |
|---|---|---|---|
| Adair | Floyd | Monroe | |
| Adams | Franklin | Montgomery | Central Iowa Community Services |
| Allamakee | Fremont | Muscatine | County Rural Offices of Social Services |
| Appanoose | Greene | O'Brien | County Social Services |
| Audubon | Grundy | Osceola | Eastern Iowa MHDS |
| Benton | Guthrie | Page | Heart of Iowa |
| Black Hawk | Hamilton | Palo Alto | MHDS of the East Central Region |
| Boone | Hancock | Plymouth | North West Iowa Care Connection |
| Bremer | Hardin | Pocahontas | Polk County Health Services |
| Buchanan | Harrison | Polk | Rolling Hills Community Services |
| Buena Vista | Henry | Pottawattamie | Sioux Rivers MHDS |
| Butler | Howard | Poweshiek | South Central Behavioral Health |
| Calhoun | Humboldt | Ringgold | Southeast Iowa Link |
| Carroll | Ida | Sac | Southern Hills Regional Mental Health |
| Cass | Iowa | Scott | Southwest Iowa MHDS |
| Cedar | Jackson | Shelby | |
| Cerro Gordo | Jasper | Sioux | |
| Cherokee | Jefferson | Story | |
| Chickasaw | Johnson | Tama | |
| Clarke | Jones | Taylor | |
| Clay | Keokuk | Union | |
| Clayton | Kossuth | Van Buren | |
| Clinton | Lee | Wapello | |
| Crawford | Linn | Warren | |
| Dallas | Louisa | Washington | |
| Davis | Lucas | Wayne | |
| Decatur | Lyon | Webster | |
| Delaware | Madison | Winnebago | |
| Des Moines | Mahaska | Winneshiek | |
| Dickinson | Marion | Woodbury | |
| Dubuque | Marshall | Worth | |
| Emmet | Mills | Wright | |
| Fayette | Mitchell | | |
| | Monona | | |

**REVOCATION SECTION**

I hereby revoke this Authorization.

Signed:_____ Date:_____

## PATIENT BILL OF RIGHTS

### Sharing Your Medical Information with Other Iowa Counties and Regions to Improve Your Care

**Purpose of Letter**

The purpose of this letter is to provide you with information about the reason sharing your medical information is necessary. You have an option to not sign this medical information release but doing so may prevent us from having a complete picture of your complete health.

**Iowa Law**

Iowa's Disclosure of Mental Health and Psychological Information, Chemical Substance Abuse, and Acquired Immune Deficiency Syndrome (AIDS) laws provide protection of your mental health, chemical and substance abuse history, and AIDS testing information. The law is very restrictive on who may see your mental health, chemical and substance abuse history, and AIDS testing information. If you receive services from multiple counties, Iowa Law prevents the counties from sharing this health information.

**HIPAA**

The Health Insurance Portability and Accountability Act (HIPAA) provides federal protection for individually identifiable health information. However, the rule also allows entities to disclose health information needed for patient care and other purposes, like the ability to bill for the care provided to you.

The Iowa laws protecting mental health, chemical and substance abuse history, and AIDS testing information were passed before HIPAA. Iowa law is more protective than HIPAA and it prevents providers and other health care entities from sharing necessary information to provide you complete care.

**Sharing Your Mental Health, Chemical and Substance Abuse History, and AIDS Testing Information Helps Iowa Counties Have a More Complete Picture of Your Health**

By signing this agreement you are allowing Iowa counties and regions to share your mental health, chemical and substance abuse history, and AIDS testing information in order to provide better care for you. We do have important safeguards in place to make sure all of your mental health, chemical and substance abuse history, and AIDS testing information is safe. Only authorized individuals will have access to your information. Nothing in this release allows improper use of your mental health, chemical and substance abuse history, and AIDS testing information.

**You Can Choose Not to Sign This Agreement**

Your privacy is important to us, so we will respect your choice on whether you want us to share your mental health, chemical and substance abuse history, and AIDS testing information with other Iowa counties and regions. You have the right to revoke this authorization at any time.

**You May Request a Copy of Your Record**

You may request a copy of your CSN record at any time, except for psychological test materials and psychotherapy notes. This includes a list of disclosures of your CSN record. The county or region may impose a reasonable, cost-based fee. That fee may consist of labor for copying your CSN record, supplies for making the copy (such as paper and ink), postage to mail your CSN record to you, and preparing an explanation or summary of your medical information.

**Questions**

If you have questions or concerns about this agreement, you can bring it up next time you're receiving care from your county. Questions should be directed to your county or region's Privacy Officer.