

**Partners 4 Families Centralized Intake  
Release of Information**

The purpose of this **RELEASE OF INFORMATION** is to help expectant parents, young children and their families receive services in Fremont and Page Counties that are the most appropriate for their family.

**Participant name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
PLEASE PRINT

If under 18 years of age, parent or legal guardian: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Maternal Child Health of Southwest Iowa and the agencies listed below, who offer home visiting services to expectant parents, young children and their families, to release information, obtain, and/or exchange my name and/or my child(ren's) name, address, phone number and referral information.

**West Central Community Action**

**Early Head Start**, P.O. Box 709, Harlan, IA 51537, 712-755-7537  
**FaDSS**, 500 ½ North Broad, Shenandoah, IA51601, 712-249-0961

**Southwest Iowa Families, Inc.**, 215 East Washington, Clarinda, IA 51632, 712-542-3501  
**Positive Family**  
**Stork's Nest**

**Page County ISU Extension**, 311 East Washington, Clarinda, IA 51632, 712-542-5171  
**Growing Strong Families**

**Fremont County ISU Extension**, P.O. Box 420, Sidney, IA 51652, 712-374-2351  
**Growing Strong Families**

\_\_\_\_\_  
**Signature of Parent(s) or Legal Guardian(s)** Date

\_\_\_\_\_  
**Address City State Zip Code Phone Number**

Signature of **Witness**/Agency Personnel

This authorization will expire 1 year from date of signature, except as specified here: \_\_\_\_\_  
(cannot exceed 1 year)

**This authorization may be revoked at any time by sending a written request to: Joan Gallagher, Taylor County Public Health, 405 Jefferson Street, Bedford, IA 51632.**

**Specific Authorization for Release of Information Protected by State or Federal Law**

I understand that unless I initial the lines below indicating my specific authorization to release information, Federal and Iowa Laws prohibit the disclosure of information relating to substance abuse, mental health and HIV related information. I specifically authorize the release of data and information relating to:

\_\_\_\_\_ 1. Substance Abuse (Alcohol/Drug Abuse) \_\_\_\_\_ 2. Mental Health (Including Psychological Testing) \_\_\_\_\_ 3. HIV-Related Information (AIDS Related Testing)

\_\_\_\_\_  
**Signature of Parent(s) or Legal Guardian(s) Date**

In order for the above information to be release, you must sign here and above. This information has been disclosed to your from records protected by federal confidentiality rules for alcohol/drug abuse records (42 CFR part 2), state law for mental health records (Iowa Code Ch. 141). These rules/law prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the 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. Civil damages and criminal penalties may be applicable to the unauthorized disclosure of this information. This federal rule relating to alcohol/drug abuse records restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.