UnityPoint Health

Des Moines

•Release ot Information BHI_J•

- Please read this form.
- Ask about any part you do not understand.
- Be sure you have your questions answered before you sign this form.

I agree for Iowa Health Des Moines to verify my insurance coverage.

I agree for_____(name of insurance company) or its agents to be given mental health information per Iowa Code Chapter 228, or as amended. I know information to be given may include mental health or drug and alcohol abuse.

I know I have the right to view what was given to the company.

I agree to the release of this information for review of possible services, payment claims, services given, or to audit claims that have been paid.

I agree to pay for mental health services if the above insurance company denies claims because I did not sign this form.

I know this release is good for records from_____(date of service) until treatment ends and all payments have been made unless I cancel this agreement.

## To Cancel this Agreement

I know I may cancel this agreement at any time by giving written notice to the Director of Medical Records at Iowa Health Des Moines. I know some information may have already been given at the time I cancel this agreement.

I agree to pay for mental health services if the above insurance company denies claims because I cancelled this agreement.

I know that to cancel this agreement or to refuse to sign this form will not affect me being able to obtain health care services.

## Prohibition of Redisclosure

This form does not authorize redisclosure of media information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch. 228) prohibits further disclosure without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Be sure you have your questions answered before you sign this form.

I agree to release of this information.

I received a copy of this form.

Sign Here → _____

Patient or Patient Representative Signature

_____

Relationship to Patient Date

# Release of Information
## Behavioral Health

REG 1009 0M
07/2010

Patient Label