

**Eyerly-Ball Community Mental Health Services**  
**Supported Community Living**  
**945 19<sup>th</sup> Street**  
**Des Moines, IA 50314**  
**515-241-0982**

**RELEASE OF INFORMATION**

CONSUMER: \_\_\_\_\_ SOC SECURITY#: \_\_\_\_\_

I, the undersigned, hereby authorize Eyerly-Ball Community Mental Health Services staff to release and/or obtain the information indicated below, regarding the above named consumer, with:

\_\_\_\_\_  
Name of Person or Agency

\_\_\_\_\_  
Complete Mailing Address

The information being released will be used for the following purpose:

- Planning and implementation of my Individual Comprehensive Plan or Individual Care Plan  
 Coordination of services  Referral for new services  
 Monitoring of services  Other (specify) \_\_\_\_\_

**INFORMATION TO BE RELEASED FROM  
EYERLY-BALL COMMUNITY MENTAL HEALTH SERVICES:**

- Yes No  
  SOCIAL HISTORY  
  PROGRESS REPORT - WRITTEN/VERBAL/ELECTRONIC  
  INDIVIDUAL COMPREHENSIVE PLAN/ SERVICE PLAN  
  ANNUAL REVIEW  
  DISCHARGE SUMMARY  
  HCBS WAIVER  
  OTHER (specify) \_\_\_\_\_

**INFORMATION TO BE OBTAINED FROM  
THE AGENCY INDICATED ABOVE:**

- Yes No  
  SOCIAL HISTORY  
  EDUCATIONAL/VOCATIONAL PLANS  
  PROGRESS SUMMARY  
  PSYCHOLOGICAL EVALUATIONS/REPORTS  
  PSYCHIATRIC ASSESSMENT/REPORTS  
  MEDICAL HISTORY  
  TREATMENT PLAN  
  DISCHARGE SUMMARY  
  HCBS WAIVER  
  FINANCIAL ELIGIBILITY  
  HIV STATUS  
  OTHER (specify) \_\_\_\_\_

This authorization shall expire on: \_\_\_\_\_

At that time the consent will automatically end (terminate), but I understand that I may withdraw my consent at any time by sending a written notice to the person or agency named above or Eyerly-Ball Community Mental Health Services. I understand that any information released prior to my consent ending or being withdrawn may be used for the purpose listed above and does not violate my right to confidentiality. I understand that I may review the information released by contacting the person or agency named above or Eyerly-Ball Community Mental Health Services. My case worker has explained this process to me. **SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:** I specifically authorize the release of data and information relating to Mental Health.

Signature of Consumer or Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Relationship if NOT the Consumer: \_\_\_\_\_

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**  
I specifically authorize the release of data and information relating to:  Substance Abuse  
 HIV-Related Information

\_\_\_\_\_  
Signature of Consumer or Legal Guardian Date

In order for this information to be released, you must sign here and above.

\_\_\_\_\_  
EBCMHS Staff: \_\_\_\_\_ Date: \_\_\_\_\_