**CONSENT TO OBTAIN AND RELEASE INFORMATION**

| Name: | Date of Birth: (MM/DD/YY) | Obtained High School Diploma or GED? ☐ Yes ☐ No<br><br>Date: |
|---|---|---|
| Current Address:<br><br>County:<br><br>Phone: | Forwarding Address:<br><br>County:<br><br>Phone: | State ID#<br><br>Date exited from Care:<br><br>DHS ☐ JCS ☐ Both ☐ |

I authorize the Iowa Department of Human Services (IDHS) and the Iowa Aftercare Services Network (IASN) to share written and oral information about my needs and the services I receive or have received, for the purpose of determining eligibility for IASN and assisting in the coordination of ongoing services and data collection. This information can only be released to the following authorized agencies of the IASN:

American Home Finding Association
Children's Square, USA
Youth and Shelter Services
Youth Homes of Mid-America
Family Resources
Foundation 2
Francis Lauer
Youth Policy Institute of Iowa
Four Oaks
Young House Family Services
Children and Families of Iowa

I understand that this information shall be kept confidential and shall be used for the purpose of determining my eligibility for aftercare services, planning and delivering my services, and ongoing coordination of aftercare related services and supports, including but not limited to the Iowa Aftercare Services program (including the Preparation for Adult Living (PAL) program) and the Medicaid for Independent Young Adults (MIYA) coverage program. 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 that may be generated during future service involvement. I understand that I can revoke my consent at any time by providing written notification. This consent shall expire the later of 1 year after termination of my involvement in the Iowa Aftercare Services Program or on my 21st birthday. I understand that IDHS will not be able to determine my eligibility for benefits if I do not complete this authorization.

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

| Authorizing Signature (*youth at least 18 years old or legal guardian*) | Date |
|---|---|
| A photocopy of this signed Authorization shall have the same force and effect as this original. | |

I understand that I am not required to authorize the release any of the following information to receive services:

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the following information, which requires specific consent under federal or state law:

| **Type of Information** | Nature and Source of Information | Authorizing Initials |
|---|---|---|
| SED: ❑ YES ❑ NO ❑ NATR[1]<br>Mental health Evaluation/treatment Including Diagnosis/Dates* | | |
| AIDS/HIV-related | | |
| Substance abuse** | | |

*Only a person 18 years of age or older or such 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.

[1] Not authorized to release (NATR)

Iowa Aftercare Services Network

Office Use Only: **Youth's Name:**

| | | |
|---|---|---|
| DHS TRANSITION PLANNING SPECIALIST<br><br>Name:<br><br>Address:<br><br>Phone:<br><br>Fax: | ☐ Not Eligible for Aftercare<br><br>Reason: | ☐ Eligible for Aftercare<br><br>**Please select if any circumstances apply:<br><br>☐ Left before 18th birthday (not eligible for room and board)<br><br>☐ In state paid foster care on 18th birthday<br><br>☐ In state paid care 6 of the previous 12 months prior to leaving care<br><br>☐ Adopted or placed in subsidized guardianship from foster care on or after age 16 (effective 10/7/08)<br><br>☐ In relative or suitable other placement. |
| IASN AGENCY:<br><br>SSA:<br><br>Address:<br><br>Phone:<br><br>Fax | IASN COORDINATOR<br><br>Phone: (515) 727-4220<br><br>Fax: (515) 727-4223 | Exception to policy granted for eligibility:<br>☐ Yes ☐ No<br><br>Eligible for voluntary foster care:<br>☐ Yes ☐ No<br><br>TPS signature : Date: |

**RECORD OF DISCLOSURES**:

(Required for mental health information)

| Date | Name of Recipient | Contents Disclosed | Sent by |
|---|---|---|---|
| | | | |
| | | | |

**NOTICE TO RECIPIENTS OF MENTAL HEALTH INFORMATION**

In accordance with the Iowa Mental Health Information Disclosure Act (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 consent 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 141.23) 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**

Federal law prohibits employment discrimination on the basis of race, color, age, religion, national origin, sex or disability. State law prohibits employment discrimination on the basis of race, color, creed, age, sex, sexual orientation, gender identity, national origin, religion, pregnancy, mental or physical disability, or political belief. State law also prohibits public accommodation (such as access to services or physical facilities) discrimination on the basis of race, color, creed, religion, sex, sexual orientation, gender identity, religion, national origin, or mental or physical disability. If you believe you have been discriminated against in any activity, facility or program of the Iowa Department of Human Services, you may file a complaint with the Department by contacting the Iowa Department of Human Services, Diversity Programs Unit 1st Fl, 1305 E Walnut St., Des Moines IA 50319-0114 or by Fax at 515-281-4243 or by email at stopit@dhs.state.ia.us.