



20 W 6th St. Ste. 306, PO Box 680, Spencer, Iowa 51301

Sharon Eckhart, ARNP, BC
Dawn Howley, ARNP, BC
Phone: 712-580-3882
Fax: 712-580-3932

Page Two of Patient Details

Patient Name: _____

D.O.B. _____

I authorize the release of any medical or mental health information necessary to process this claim. I authorize payment of benefits to any and all providers of services rendered by SPCS.

X _____ Date: _____
Patient/Guardian Signature

I authorize psychiatric care at SPCS. I permit the doctor, his/her employees and all other persons caring for me to treat me in ways they judge beneficial to me. I understand that this may include exams, tests, medical and/or psychiatric treatment.

X _____ Date: _____
Patient/Guardian Signature

I authorize SPCS to leave messages on an answering machine or voice mail.

X _____ Date: _____
Patient/Guardian Signature



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AUTHORIZATION TO FAX Mental Health Information:

Patient's Name _____ Date of Birth _____

Previous Name: _____ Soc Sec Number _____

I request and authorize _____ SPCS _____ to release mental health information by facsimile transmission to:

Name: _____

Address: _____

City: _____ State: _____ Zip _____

This request and authorization applies to:

-----All Mental Health Information

I understand and accept the risk of diminished security of Confidential Mental Health Information which is transmitted by FAX transmission due to misdirection of telephone communication. I understand that all due attention will be extended by staff of Spencer Psychiatric & Counseling Services, L.L.C., but that receipt only by the intended recipient can not be guaranteed. All FAX transmissions will be clearly identified as Confidential Mental Health Information protected by federal and state law.

This authorization is effective for all transmissions and expires one year after I no longer have had services at this facility.

Parent/Guardian/Patient Signature _____ Date _____



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Authorization for Use and Disclosure of Information for Purposes Requested by a Healthcare Office:

I, Patient Name--_____ DOB-_____

Authorize SPCS to: Use and/or disclose the following Protected Health Information to:

Agency--_____

Psychiatric Evaluation Psycho/Social Evaluation Substance Abuse Medication Notes Medication List HIV/AIDS Laboratory Results Verbal and Written

All of the Above

This Protected Health Information is being used or disclosed for the following purposes: Treatment, Continuity of Care, Collaboration, Referral and/or health care operations. This Authorization shall be in force and effect until 12 months from the date signed at which time this Authorization to use or disclosed this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS 20 W 6th St. Ste. 306 PO Box 680 Spencer, IA 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. SPCS will not condition my treatment on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as permitted under federal or state law. I have the right to refuse to sign this Authorization. Confidentiality of mental health information is protected by federal and state law, Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative (PRINT)

Patient SS Number

Description of Personal Representative's Authority



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Authorization for Use and Disclosure of Information for Purposes Requested by a Healthcare Office:

I, Patient Name--_____ DOB-_____

Authorize SPCS to: Use and/or disclose the following Protected Health Information to:

Agency-Midwest Christian Services_____

Psychiatric Evaluation Psycho/Social Evaluation Substance Abuse Medication Notes Medication List HIV/AIDS Laboratory Results Verbal and Written

-----All of the Above

This Protected Health Information is being used or disclosed for the following purposes: Treatment, Continuity of Care, Collaboration, Referral and/or health care operations. This Authorization shall be in force and effect until 12 months from the date signed at which time this Authorization to use or disclosed this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS 20 W 6th St. Ste. 306 PO Box 680 Spencer, IA 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. SPCS will not condition my treatment on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as permitted under federal or state law. I have the right to refuse to sign this Authorization. Confidentiality of mental health information is protected by federal and state law, Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

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Authorization for Use and Disclosure of Information for Purposes Requested by a Healthcare Office:

I, Patient Name--_____ DOB-_____

Authorize SPCS to: Use and/or disclose the following Protected Health Information to:

Agency-Mercy Medical Clinic_____

Psychiatric Evaluation Psycho/Social Evaluation Substance Abuse Medication Notes Medication List HIV/AIDS Laboratory Results Verbal and Written

-----All of the Above

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Authorization for Use and Disclosure of Information for Purposes Requested by a Healthcare Office:

I, Patient Name--_____ DOB-_____

Authorize SPCS to: Use and/or disclose the following Protected Health Information to:

Agency-Royster & Royster_____

Psychiatric Evaluation Psycho/Social Evaluation Substance Abuse Medication Notes Medication List HIV/AIDS Laboratory Results Verbal and Written

All of the Above

This Protected Health Information is being used or disclosed for the following purposes: Treatment, Continuity of Care, Collaboration, Referral and/or health care operations. This Authorization shall be in force and effect until 12 months from the date signed at which time this Authorization to use or disclosed this Protected Health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS 20 W 6th St. Ste. 306 PO Box 680 Spencer, IA 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. SPCS will not condition my treatment on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the Protected Health Information to be used or disclosed as permitted under federal or state law. I have the right to refuse to sign this Authorization. Confidentiality of mental health information is protected by federal and state law, Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

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Authorization/Request for Release of Information for Purposes Requested by a Healthcare Office from another Covered Entity

I, Patient Name- _____ DOB- _____

Hereby authorize, Agency—Midwest Christian Services

To disclose the following Protected Health Information to SPCS:

- Medical History/Exam
 Lab Results
 Substance Abuse
 Inpatient Records
 Progress Notes
 HIV/AIDS
 Psychological Reports
 Medication List
 Verbal and Written
 Social History
 Psychiatric Evaluation
 - All of the Above Information.

This Protected Health Information is being used or disclosed to carry out treatment, continuity of care, collaboration, payment and/or health care operations of SPCS. This Authorization shall be in force and effect until 12 months from signature date at which time this authorization to use or disclose this Protected health Information expires. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to SPCS at 20 W 6th St. Ste. 306 PO Box 680, Spencer, Iowa 51301. I understand that a revocation is not effective to the extent that SPCS has relied on the use or disclosure of the Protected Health information. It is SPCS policy not to disclose Protected Health Information received from another covered healthcare entity. SPCS will not condition my treatment, payment or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide Authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this Release. Confidentiality of mental health information is protected by federal and state law, Chapter 228 of the Iowa code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2 and cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

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Authorization/Request for Release of Information for Purposes Requested by a Healthcare Office from another Covered Entity

I, Patient Name- _____ DOB- _____

Hereby authorize, Agency—Mercy Medical Clinic

To disclose the following Protected Health Information to SPCS:

- Medical History/Exam
 Lab Results
 Substance Abuse
 Inpatient Records
 Progress Notes
 HIV/AIDS
 Psychological Reports
 Medication List
 Verbal and Written
 Social History
 Psychiatric Evaluation
 - All of the Above Information.

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I, Patient Name- _____ DOB- _____

Hereby authorize, Agency—Royster & Royster

To disclose the following Protected Health Information to SPCS:

- Medical History/Exam
 Lab Results
 Substance Abuse
 Inpatient Records
 Progress Notes
 HIV/AIDS
 Psychological Reports
 Medication List
 Verbal and Written
 Social History
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I, Patient Name- _____ DOB- _____

Hereby authorize, Agency-- _____

To disclose the following Protected Health Information to SPCS:

- Medical History/Exam
- Lab Results
- Substance Abuse
- Inpatient Records
- Progress Notes
- HIV/AIDS
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Patients Right and Responsibilities

Patient's Name: _____

Date of Birth: _____

Spencer Psychiatric & Counseling Services LLC is committed to treating patients in a manner that respects their rights. We recognize that each patient has the right to the following:

The right to receive information about your managed care organizations, its services, its practitioners and providers, and the patient's rights and responsibilities.

The right to be treated with respect and recognition of their dignity and right to privacy.

The right to participate with practitioners in decision making regarding their health care.

The right to full discussion of treatment options.

The right to voice complaints or appeals about the managed care organization of the care provided.

Each patient is responsible for cooperating with those providing health care services to the patient and shall have the following responsibilities.

The responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.

The responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

Patient/Parent/Guardian Signature

Date-_____

I have an advanced psychiatric directive. Yes No