Iowa Nurse Assistance Program (INAP)

Iowa Nurse Assistance Program
400 SW 8th Street, Suite B
Des Moines, IA 50309-4685

Phone: 515-725-4008
Fax: 515-725-4017
Email: INAP@iowa.gov

AUTHORIZATION TO RELEASE INFORMATION

I**, (NAME, DOB) _____**

Do hereby authorize a disclosure of records concerning myself to the Iowa Nurse Assistance Program (INAP) from_____

And from the INAP to_____
This release includes records of a public, private or confidential nature and for the purposes of correspondence.

I acknowledge that the information released to and from the INAP may include material regarding substance abuse, mental health, and/or HIV/AIDS that is protected by federal and/or state law. **I specifically authorize the release of confidential information to and from the INAP relating to:**

[x] Substance Abuse or Dependence [x] Mental Health [x] INAP involvement (x) other

I further agree and the INAP may exchange confidential information and records, including, but not limited to the following records:

[x] Consultation	[x] History & Physical	[x] Social History
[x] Assessment/Evaluation	[x] Chemical Screening Results	[x] Treatment Status
[x] Discharge Summary	[x] Psychiatric Treatment	[x] Lab, X-ray, EKG

[x] Confirmation of my involvement in the IPHP and information about my compliance with Program requirements. [x] As much information as the INAP deems reasonably necessary for the purposes set forth in this release. This release allows for an open exchange of information between INAP and _____.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the INAP pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the INAP, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective for the length of my participation in the INAP and for two months afterwards. I understand I have the right to revoke this authorization in writing, except to the extent that the INAP or has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Nurse **Date**

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical 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) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, 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.

Revised 03/08/2017