



AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name: _____ Date of Birth: _____

I hereby authorize Phelps Counseling & Consulting to release and/or obtain information concerning the above named client with:
Person/Agency: _____ Phone Number: _____

INFORMATION TO BE RELEASED AND/OR REQUESTED FROM PHELPS COUNSELING & CONSULTING

- checkbox Evaluation Results/Assessment/Forms
checkbox Diagnosis/Medication list
checkbox Treatment Summary or Service Plan
checkbox Progress/Prognosis/Treatment
checkbox Discharge Summary
checkbox Billing information
checkbox Social & Family History
checkbox Records of Contact
checkbox Legal Status/Legal History
checkbox Educational/Vocational Plans
checkbox Other: _____

THE INFORMATION BEING RELEASED AND/OR REQUESTED WILL BE USED FOR THE FOLLOWING PURPOSE(S):

- checkbox Ongoing evaluation and treatment
checkbox Coordination of services and supports
checkbox Coordination of medical treatment
checkbox Referral
checkbox Academic planning and placement
checkbox Personal file
checkbox Litigation
checkbox Insurance
checkbox Other: _____

This agreement will expire 2 years from the date of signature, unless previously revoked or otherwise indicated (specify date or event of expiration): _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Phelps Counseling & Consulting. I understand that the person or agency receiving this information, in accordance with state regulations, will be notified not to disclose this information without further written consent. However, I understand that Phelps Counseling & Consulting cannot guarantee that the recipient will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosures of such information unless further disclosures are expressly permitted by written consent of the client or as otherwise permitted under federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that any release which was made prior to my cancelation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting Phelps Counseling & Consulting at the above address. I understand the Phelps Counseling & Consulting may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disability except where disclosure of the information is necessary for the treatment.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

As the client/legal representative initialing, I acknowledge Federal and/or State law and specifically authorize the release of information relating to: Substance/Alcohol Use/ Abuse _____ Mental Health _____ HIV/AIDS related info _____ Infectious Disease _____

Signature of Client/Legal Representative: _____ Date: _____

Signature of Minor, if required: _____

Witness Signature: _____

_____ Check here if patient/client refuses to sign authorization.

_____ Check here if patient/client would like a copy of this authorization

To the recipient of mental health information: Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in Iowa Code 228. The unauthorized release of mental health information is unlawful and civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.