Authorization for Release of Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

I, hereby authorize Iowa Family Counseling, LLC to disclose, obtain and/or exchange protected health information either verbally and/or in writing to the following individual:

**EMERGENCY CONTACT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

For the following purpose(s):

\_\_\_All of the following: \_\_\_Treatment and assessment \_\_\_Coordination of Care

\_\_\_Referral for services \_\_\_Other: emergency contact\_\_\_\_\_\_\_\_\_\_\_

Specific information to be released:

\_\_\_All of the following: \_\_\_Assessment & diagnosis \_\_\_Social history

\_\_\_Discharge \_\_\_Test results \_\_\_Treatment plan and goals \_\_\_Medical history \_\_\_Presence and progress in treatment

\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific authorization for release of information protected by state and/or federal law concerning mental health, substance abuse treatment, STD/HIV/AIDS-related information and genetic information:

I understand that this will include information related to the following categories unless I specifically deny the release. **Initial any category NOT to be released.**

\_\_\_\_\_Behavioral and mental health \_\_\_\_\_Alcohol, drug and other substance abuse

\_\_\_\_\_Genetic-related information \_\_\_\_\_Sexually transmitted diseases, HIV, AIDS

I understand that by signing this release of information, I am authorizing Iowa Family Counseling LLC to disclose my health information to the person/entity listed above and that any health information or other confidential information in the possession of the person/entity listed above may be disclosed to Iowa Family Counseling LLC.

I understand this authorization is valid for 12 monthsfrom the date signed unless specified otherwise, and will cease to be valid upon my discharge from treatment at Iowa Family Counseling LLC. This authorization to release information may be revoked at any time except to the extent that action has been taken in reliance upon, with written notice given to Iowa Family Counseling, LLC. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by Iowa Family Counseling’s confidentiality policies. I waive any right of privacy that I may have in connection with the disclosures hereby authorization. I understand that I have the right to inspect the disclosed information being exchanged at any time, and that by signing this release of information, it is not a condition of receiving services with Iowa Family Counseling. A photocopy or exact reproduction of this Authorization of information shall have the same effect as the original.

By signing below, I acknowledge that this form has been fully explained to me, and I certify that I understand its contents.

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Client Signature Date

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Parent/Guardian/Legal Representative Signature Date

* I decline to release this information for myself or child/representee