Central Iowa Psychological Services

Compassionate, Whole Person Care, Where You Matter

Authorization For Release of Protected Mental Health Information

I, ____ , born, _________________________, authorize Central Iowa Psychological Services to ____send to / ____obtain from:

Name: ____Phone: __________________

Address: ______________________________________ City: _________________ State: _______ Zip: ______________

the following information from my records: (please **initial**/specify below)

I authorize release of:

____ Psychological testing results
____Assessment
____ Psychiatric evaluation
____Treatment Status
____ Academic/School Information
______Hospitalization summaries
______ Social history
______ Medical information
_____ Psychotherapy Notes
____Other ______________________
____Acknowledgement of service
____ Summary Reports
____ Diagnosis
____ Treatment Plan
____Substance Abuse Records

____ As much information as either/both parties, in their full discretion, deem reasonably necessary for the purposes set forth by me for release.

The above information is being disclosed only for the purpose(s) of:

____Diagnosis
____ Arrange financing/payment
____ Other ____
____Treatment
____Coordinate services
____ Assist in legal representation
___ School interventions

I give permission for the above information to be disclosed via ____ phone call, ____ email, ____ fax, ____ mail, ____in-person

I understand that I may revoke this authorization at any time by providing written notice to my therapist and to the named recipient of the disclosed mental health information. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. **After one year, this consent automatically expires**.

I have been informed what information will be given, its purpose, and who will receive the information. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that I have the right to inspect the information to be disclosed upon proper notification to and under appropriate conditions established by Central Iowa Psychological Services.

Notice to Recipient: **Confidential**

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, 45 C.F.R. HIPAA) and State requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient, 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.

I acknowledge that the information to be released may include material that is protected by state and/or federal law applicable to mental health, and/or drug/alcohol abuse, and/or HIV/AIDS or all three. My signature authorizes release of all such information as specified above.

____
Client Signature

____
Parent/Guardian/Representative Signature

____
If Guardian/Representative – Please State Relationship To Client

____
Date Signed

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