AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION

FAMILY LEGACY COUNSELING

5415 NW 88th Street Johnston, IA 50131 / 275 NE Venture Drive Suite 5 Waukee, IA 50263
515-727-1338 (phone) / 515-727-1340 (fax)

Patient's Legal Name _____ Date of Birth _____

By signing this form, I am allowing Family Legacy Counseling (and the clinician's name listed below) to release and/or obtain information from the person, school, facility, or physician listed below.

I authorize _____ to release or obtain information from:

_____
Name of Person, Business, Church, School, Facility, or Physician

_____
Complete Mailing Address City, State, Zip Code

_____
Phone and/or Fax Numbers

Please check information to be obtained or released:

_____Diagnosis
_____Medical History
_____Treatment Plan/Outcome
_____Discharge Summary
_____Dates of Service
_____Psychiatric History/Evaluation
_____Psychological Testing Information
_____Other (Please Specify) _____

I acknowledge such information cannot be disclosed without my written consent unless otherwise provided by law. I have the right to revoke this authorization at any time. Any revocation will be done in writing to Family Legacy Counseling and any information previously authorized and released will not be subject to revocation. I acknowledge and authorize that the information indicated on this form will be sent to the individuals listed above. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound by the provisions of this law. However, re-disclosure of this information is prohibited by the Iowa Mental Health Code (Chapter 228) and will not be copied, shared, or re-released, except as consistent with the authorized information checked above.
I understand that I am not required to sign this authorization, and that Family Legacy Counseling will not refuse me treatment if I refuse to sign. I may review the disclosed information or ask questions at any time by contacting the office staff or my mental health clinician at Family Legacy Counseling.

I understand that the information may be released electronically or faxed for expediency and may include information in the following categories unless I specifically deny this release (initial any category **NOT** to be released).
Substance Abuse _____ Mental Health _____ HIV-related information _____

This consent will expire **two (2) years** from the date of signature, or as indicated (specify number of day or months) _____ unless cancelled by the patient /guardian.

_____ _____ _____
Signature/Signature of parent or authorized representative Printed Name Date

_____ _____ _____
Relationship, if not the patient Witness Signature (if required) Date