



Central Iowa Psychological Services

Compassionate, Whole Person Care, Where You Matter

Authorization For Release of 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 check/specify below)

I authorize release of:

- | | | |
|--------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Psychological testing results | <input type="checkbox"/> Hospitalization summaries | <input type="checkbox"/> Acknowledgement of service |
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Social history | <input type="checkbox"/> Summary Reports |
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Medical information | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Treatment Status | <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Other _____ | | |

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:

- | | | |
|----------------------------------------------------|----------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Treatment | <input type="checkbox"/> Assist in legal representation |
| <input type="checkbox"/> Arrange financing/payment | <input type="checkbox"/> Coordinate services | <input type="checkbox"/> Other _____ |

I give permission for the above information to be disclosed via phone call, email, fax, mail, face to face contact

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

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.

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, 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.

Client Signature

Parent/Guardian/Representative Signature

If Guardian/Representative – Please State Relationship To Client

Date Signed

319 Lincoln Way
Ames, Iowa 50010
Phone: 515-233-1122

3737 Woodland Ave., Suite 415
West Des Moines, IA 50266
Phone: 515-222-1999

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